THE BUSINESS OF CARING:

PRACTICE NURSES

IN PRIMARY HEALTH CARE

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Belinda Mortlock

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ABSTRACT

The professional strategies, relational positioning and day-to-day work of practice nurses form the focus of this thesis. It utilises and extends the ways Anne Witz (1994) and Andrew Abbott (1981,1988) have theorized about nursing, and the construction of professions and professional boundaries. While their salaries are largely subsidized by the regional health authorities, practice nurses are employed by general practitioners. In this context they use a variety of discursive strategies to construct themselves as "collegial practitioners".

Drawing on a survey of practice nurses in Canterbury, fieldwork in general practices and indepth interviews with practice nurses, this study challenges any simplistic view of practice nurses as "subordinate" health care workers. It indicates the ways in which practice nurses are actively negotiating their relationships with general practitioners against a background of increasing commitment by regional health authorities to health promotion, and the general restructuring of primary health care delivery. The thesis also addresses the importance of the "caring" work done by practice nurses within the individual businesses of general practice. It analyses the professionalisation of their competence in caring "for" and caring "about". The gendered features of the ways in which practice nurses balance the demands of general practitioners and patients/clients is also a crucial component of this study.

ACKNOWLEDGEMENTS

This study would not have been possible without the generous participation of practice nurses in Canterbury. This includes all the nurses who responded to the questionnaire, many of who added articulate comments; the nurses who enthusiastically invited me into their workplaces and allowed me to work alongside them; and the nurses who readily volunteered their time and energy to be interviewed about their work as practice nurses. Especially deserving of gratitude are the members of the sub-committee, Canterbury Practice Nurse Division, formed to assist with the drafting and pretesting of the questionnaire: Lynne Gibbons, Allison Harrington, Joan Porteous and Elizabeth McKenzie. I am grateful to the Department of Sociology for assistance with printing the questionnaire. I am indebted to my two supervisors, Rosemary Du Plessis and Terry Austrin, for their inspiration, considerable expertise, and constant encouragement. I am very grateful to Kerry Jacobs for his helpful comments on Chapter Four. Many other people have contributed to this study through their interest and support. I would especially like to thank Margaret Hawke, Susie Marks, Christine McNeill, Camilla Obel, Suzanne Phibbs, and Elizabeth Tully. Finally, this thesis could not have been written without the considerable patience and love of the "significant others" in my life: Simon, Thomas, Jane and Alice. Thank you to you all.

TABLE OF CONTENTS

CHAPTER ONE

THE CASE OF PRACTICE NURSING

"But what is there about practice nursing that could possibly be interesting?"
(Practice nurse employed in a suburban general practice).

Analysis of health care delivery in New Zealand demands attention to the intersections between state policy, private enterprise and the professional strategies of those working in the health system. In a context characterised by implementation of changes in the delivery of primary health care services, the position of practice nurses becomes particularly interesting. Employed by general practitioners to provide nursing services in privately owned general practices, practice nurses claim to work from a wellness model and excel in teaching people to stay healthy (Hounsell,1992:41). The focus of nurses on health rather than illness coincides with the aims of state managers of health care services[1], and public support for better primary and preventive care[2]. The medical profession is experiencing some loss of prestige, amid a climate of fear and uncertainty about seemingly unmanageable diseases such as AIDS.

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[1] The vision of the Southern Regional Health Authority for the future of primary care is for services which are not only easily accessible, acceptable to the different needs of the population, of high quality and safe, and well co-ordinated with other services, but are also cost effective and emphasise good health (Southern Regional Health Authority,1994:5-6). The Southern Regional Health Authority (1994:3), which receives a population based funding pool and is responsible for purchasing health services for the southern geographical area, wants to keep people healthy, and improve the uptake on preventive and screening services.

[2] See *Core Health and Disability Services for 1993/4: The First Report of the National Advisory Committee.* The National Advisory Committee was appointed to advise the Minister of Health of the services New Zealanders may expect to receive under a publicly funded health care system, and was required to consult widely with the public, and with health and disability support professionals.

Despite claims by the medical profession of increasing "technical efficiency" in the delivery of medical care, the increase in degenerative diseases characteristic of industrial societies points to a corresponding "neglect of prevention and the marginalization of care" (Carpenter,1993:105). The position of nurses as the health professionals most obligated to "care" is crucial in any critical examination of primary and preventive care services.

My interest in nurses who work in general practice begins with my own background as a registered nurse. Although I have not practised as a nurse since 1976, my professional identity has had a significant influence on the kinds of issues I wanted to understand as a sociologist, particularly issues relating to nurses' relationships with patients and other health professionals. I became interested in nurses who work in general practice after engaging in research among nurses who work as "independent" practitioners, an emerging occupational group[3]. Simon Upton, former Minister of Health, argued in 1992 that reform of the delivery of primary health care services offered opportunities for practice nurses to realise autonomy from their employing general practitioners (1992:3). My initial interest was in how practice nurses might realise opportunities for autonomous practice as primary health care professionals.

While my interest in this field was initially in the situation of "independent" nurse practitioners, most practice nurses are not particularly receptive to the possibilities of acting as "independent" practitioners. They are often concerned about the uncertainty surrounding the continued provision of the practice nurse salary subsidy, offered by the Ministry of Health to general

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[3] To practise as an "independent" nursing practitioner is to practice independent of medical doctors. There are now 47 Independent Nursing Practices in New Zealand. The most financially successful of these practices appears to be the Nelson Independent Nursing Practice which began business by providing family planning and sex education services, a service previously lacking in Nelson (Sjoquist,1995:A16).

practitioners to facilitate the provision of practice nursing services within general practice. General practitioners are currently offered a subsidy of $11.00 per hour for 30 hours a week, for up to 52 weeks a year per full-time equivalent general practitioner to employ a practice nurse (*Health Benefits Letter*[4],1991:6). Although practice nurses constitute the largest group of nurses working in primary health care, they are currently the lowest paid community nurses (Beckingsale,1994:37). According to Anne Manchester, co-editor of *Kai Tiaki: Nursing New Zealand*:

> Employing general practitioners will top this (the salary subsidy) up from anywhere between $2.65 an hour to $8.49 an hour. Some may only be paying their nurses $11.00 an hour or less (Manchester,1995:13).

Despite the low levels of remuneration, many practice nurses distance themselves from collective action that might be interpreted as "political" in a formal sense. They appear to be willing participants of a "team" which, if the doctor-nurse "game" identified by Stein, Watts and Howell (1990) works efficiently, assumes aspects of a "special" relationship of mutual respect and interdependence. At the same time, the research on which this thesis is based indicates that many practice nurses also express contradictory and ambiguous feelings about their relational positioning in general practice. These contradictory feelings are most acute when the nurses are required to combine health "care" with attention to the needs of a small business. Through attention to nurse practitioners working for doctors in community based general practices, this thesis documents the complex relationship

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[4] The *Health Benefits Letter* was produced by the Benefits Payment Office of the former Department of Health, which administered all the primary care subsidies. After the former Department of Health was restructured to become a policy only unit, the Benefits Payment Office became jointly owned by the four regional health authorities, and the name changed to Health Benefits Ltd. Despite these changes, the terms of the practice nurse salary subsidy provision remain the same as in July,1991.

between the gendered and professional work of nurses, publicly funded primary health care and private enterprise.

1.2 The development of the practice nurse salary subsidy scheme

The practice nurse salary subsidy began as an initiative to improve rural medical services following the recommendations of a working party which met in 1968 (McLennan,1984:1). The provision of the subsidy was expected to encourage doctors to work in rural areas (McLennan,1984:1). It was assumed that nurses would perform the more "routine" medical tasks, "freeing the doctor for tasks only he/she could do" (Hounsell,1993:3). Introduced in 1970, the subsidy took the form of payment to rural doctors of half a nurse's salary, up to $25.00 per week, but the doctor could also claim an additional 75 cents for each domiciliary visit made by the nurse (McLennan,1984:1). The Medical Association of New Zealand recommended to its general practitioner members who took advantage of the subsidy that patients should not be charged for "services provided solely by the nurse" (McLennan,1984:1).

In 1974 the scheme was altered to include a 100% subsidy, offered to doctors working in urban areas for up to 30 hours a week maximum for a solo general practitioner (McLennan,1984:2). The reason given for this additional provision was "the Government's concern that the standard of medical care was dropping" due to the increasing demand for general practitioner services and a corresponding overloading of doctors (McLennan,1984:1). Rural general practitioners could elect to adopt the 100% scheme, but the 50% scheme with the allowance for domiciliary visiting, was not available to urban doctors until 1977, when it was decided to encourage home visiting by practice nurses employed by doctors in urban general practices. A vehicle allowance was added to the 100% scheme, and the maximum hours increased to 40 (McLennan,1984:2). Although the 50% scheme declined in popularity

in the 1970s (McLennan,1984:2), the two subsidy schemes continued with minor adjustments until 1986.

The provision of the salary subsidy scheme is seemingly an exception to the ideals of a competitive health market where primary care providers manage the financial effects of their clinical decisions. In July 1986, when the Fourth Labour Government was attempting to contain spiralling health costs, the two employment subsidy schemes offered to general practitioners were "reduced" to one subsidy of 63%[5]. Paradoxically, amid an aggressive "rolling back of the state" (Rudd,1990:83) the private businesses of general practice were provided with continued funding for practice nurses, without a great deal of specificity[6] with respect to the work of these nurses, and no separate system of accountability[7]. In Canterbury, where the 100% scheme had been utilised

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[5] In a letter received from Niall Holland, Postgraduate Tutor in General Practice, in reply to a letter I had written to the Canterbury Branch of the Royal New Zealand College of General Practitioners requesting permission to proceed with the component of the research which involved fieldwork in selected general practices, he wrote "The subsidy of $11.00 an hour includes 12.5% GST which has to be returned to the Government. In effect this reduces the subsidy to, I think 63% of the Nurses' wage". See Appendix E for a copy of this letter. The vehicle allowance is no longer provided, nor an allowance for domiciliary visits by practice nurses.

[6] The objectives of the practice nurse salary subsidy scheme are very broad. They are: to improve the range, quality and accessibility of primary health care services; encourage health promotion, education, disease prevention and health maintenance; encourage the wider provision of practice nursing services throughout New Zealand; and ensure there is support, accountability and quality assurance to provide quality nursing services (Department of Health,1991:6).

[7] The salary subsidy is not monitored for abuse (Hounsell,1993:6) in terms of the work general practitioners require nurses to perform. In 1990 the New Zealand Nurses' Association (now New Zealand Nurses' Organisation) published *Standards of Practice for Practice Nursing*, a demonstration that the nurses' wanted "to be professionally accountable for their practice"

to provide district nursing services from rural general practices, rural general practitioners refused to fund the difference for practice nurses working as domiciliary nurses (Clausen,1994:29)[8]. The former North Canterbury Hospital Board, now Healthlink South, agreed to continue the funding to general practitioners for the cost of providing nursing services in rural Canterbury (Clausen,1994:29).

In 1996 the salary subsidy scheme persists and is a factor inhibiting the development of independent nursing practices. According to Simon Upton, former Minister of Health:

> The current system of benefits and subsidies has played a part in making nurses reluctant to take the steps into private practice. Subsidies are traditionally GP related, a disincentive to nurses to try it on their own (1992:3).

There are, of course, other factors which inhibit primary health care nurses "trying it on their own". The "gatekeeping" privileges of general practitioners constrain nurses from referring patient/clients to medical specialists or institutions. Practice nurses cannot sign forms for laboratory tests or Xrays. A nurse can look in a child's ear and identify an ear infection, but she cannot legally prescribe antibiotics or medication other than those which can be purchased over the pharmacy counter. Any patient/client who wishes to purchase nursing services cannot process Community Service Cards for this purpose. They cannot claim medical insurance nor claim from Accident Compensation for nursing services.

1.3 The development of practice nursing as an occupational specialty

Practice nursing as an occupational specialty was significantly shaped by the

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(Brash, in New Zealand Nurses' Association,1990:3).

[8] The Nurse Maude District Nursing Association, unique to Canterbury, does not provide rural district nursing services (Clausen,1994:29).

offer of a state subsidy to medical doctors which was directly related to an increased demand for general practice medical services. Although the provision of the subsidy meant that the nurses who worked in general practice had the bulk of their wages paid by the state, they were employed by general practitioners as the doctor's "assistants" (Thomson,1978:84; Collins,1996:84). The hospital based training of nurses in the 1960s did not focus on "taking responsibility" for primary health care nor initiatives for community based nursing. The relationship of employment between doctors and nurses, "a structure which is well known for its inflexibility" (Thomson,1978:84), together with a liberal interpretation of "routine" work, led in some cases to abuse of the subsidy provision. Doreen Hounsell, 1994 Chairperson of the National Practice Nurse Section, describes these cases in this way:

> Here was a free worker, provided by the government,...competent and valuable...still considered an employee of the GP even when her entire salary was paid by the state. We saw nurses in general medical practice but not always providing a nursing service. Too often nurses were doing office and reception work, answering telephones, cleaning, and even babysitting, and little chance was given for the nurse to widen her scope (Hounsell,1992:40).

The potential "bigger role for the practice nurse - that of a nurse practitioner", suggested by Dr Carson (1978:78), a general practitioner from Christchurch, has taken time to evolve. In 1984 a survey of fully subsidised practice nursing[9] concluded that "general practice nursing is now an established part of the nursing profession", one which deserves "proper description and recognition... and a need for in-service education" (McLennan,1984:34). Postgraduate education for practice nurses was introduced first in Christchurch through the establishment of the position of

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[9] *A Survey of the Fully Subsidised General Practice Nurse* (McLennan,1984) was funded by the Medical Research Council and carried out by members of the Wellington Research Committee of the Wellington Faculty of the Royal New Zealand College of General Practitioners.

Postgraduate Tutor of Practice Nursing[10] in 1988. The inaugural issue of the journal *New Zealand Practice Nurse*, another Canterbury initiative[11], was published in June 1992. By June 1992, there were over 2000 practice nurses in New Zealand, the largest group of nurses working in primary health (Hounsell,1992a:48). The first National Practice Nurse Conference, New Zealand Nurses' Association[12], was held in 1991. The 1994 National Practice Nurse Conference, New Zealand Nurses' Organisation, celebrated twenty-five years of practice nursing.

The isolation of individual businesses of general practice and employment by various general practitioners, all with diverse ideas of how nurses should be utilised, provides potential for a diversity of nursing practice. A pilot study undertaken in 1992, involving six practice nurses in Canterbury, which I completed as part of the course requirements for an Honours paper, raised a number of interesting sociological questions. Some nurses in this study complained that much of their time was taken up with reception and clerical duties, while other nurses found they were able to extend their skills into areas traditionally reserved for general practitioners or social workers. Practice nursing as an occupational specialty was consequently often difficult for practice nurses to define. The boundaries of "professional" work in general practice seemed much more flexible than I had ever encountered during my period of employment as a registered nurse. The contradictory positioning of practice nurses and the range of work done by many nurses,

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[10] The position of Postgraduate Tutor of Practice Nursing is a part-time position situated in the Clinical School of Medicine, and funded through sponsorship.

[11] This initiative came from a Christchurch based general practitioner and his wife, a former practice nurse. This journal is now incorporated in a new journal *Primary Health Care New Zealand*, first issued in February, 1996.

[12] The New Zealand Nurses' Association and the New Zealand Nurses' Union amalgamated on 1st April 1993, and is now known as the New Zealand Nurses' Organisation.

hinted at a complexity of nursing practice which challenged any simple understandings of practice nurses as fixed in an assumed "subordinate" position. I became convinced that analysis of this complexity demanded a more comprehensive period of research.

This thesis seeks to understand how practice nurses interpret their place in the complex web of social relations, professional practice and commercial and state subsidised work which constitutes primary health care. It examines the extent to which the visibility of practice nurses as "health professionals" is limited by their status as employees. It explores why most practice nurses prefer to work as part of the doctor/nurse "team" - rather than as autonomous health professionals, or as part of a nurse/nurse "team". It challenges assumptions about the fixed nature of subordination of nurses in relation to their employing doctors, and does this by placing practice nurses at the centre of the analysis of primary health care delivery rather than the general practitioners who are usually assumed to be the central actors in primary health care.

1.4 Research design

The research on which this thesis is based involved the utilisation of both quantitative and qualitative research strategies and was informed by feminist theory. Encouraged by Jayaratne and Stewart's arguments that it was timely and appropriate for feminist researchers to use methods which combined quantitative and qualitative research methods (1991:102), I decided to use a range of research techniques. My interest in producing research findings which were useful to practice nurses, general practitioners, regional health authorities, and health policy makers, led to the decision to begin the study with a survey of practice nurses in Canterbury. I anticipated that the drafting and distribution of a survey would enable me to work with, and share research findings with, practice nurses and their professional organisation, the Canterbury Practice Nurse Division. The questionnaire was also a way in which I could tell practice nurses about my study, and through which nurses

could indicate a willingness to participate further in the qualitative components of the research process.

The second and third stages of the research were qualitatively orientated and involved opportunities for fieldwork through informal participation in selected general practices and indepth interviews with a range of practice nurses who indicated on their questionnaires that they were prepared to talk in more detail about their work. This part of the research design was necessarily flexible. Opportunities to observe in different general practices depended not only on nurses' responses to the survey, but also on the permission of the general practitioners who employed them.

1.5 The research process

I began by writing a letter to the Canterbury Practice Nurse Division, the nurses' professional organisation, asking the committee for their formal consent to proceed with the study. With this letter I enclosed a Discussion Document (Appendix A) consisting of an abstract of the project, together with a description of the context, questions which might arise from such a context, methodology, research design, and ethical concerns. I received a favourable reply (Appendix B) which included the names of a sub-committee which had been formed to work with me.

I met with members of this sub-committee to discuss the draft of a questionnaire I had prepared. The nurses suggested questions for inclusion and later pretested the questionnaire. The involvement of these nurses was crucial to this study. Through the Canterbury Practice Nurse Division and the postgraduate tutor I obtained the names and addresses of practice nurses in the Canterbury area. The former Department of Health had the names of general practitioners who were provided with the subsidy to employ practice nurses, but not the names of the practice nurses employed by general practitioners. Although the list used by the postgraduate tutor did not include

every practice nurse employed in the Canterbury area, it was the most comprehensive list available.

At the beginning of September 1993 I posted 236 questionnaires (See Appendix C for copy) to practice nurses in the Canterbury area. Included with the questionnaire was a letter from the Head of Department of Sociology, University of Canterbury. This letter introduced me as a student in the department's Masters' programme and included the names of my supervisors, Rosemary Du Plessis and Terry Austrin. Also included was a stamped addressed envelope which the nurses could use to return the completed questionnaires.

At the same time, I inserted a message to practice nurses in the newsletter distributed by the Canterbury Practice Nurse Division, introducing myself and the research. The purpose of this notice was to encourage practice nurses to respond to the questionnaire, and also to encourage approaches from nurses who might be interested in participating in other aspects of the study. I also hoped to make contact with any nurses who had not received a copy of the questionnaire.

One hundred and twenty-two questionnaires (**52%**) were returned. The replies to the questionnaire were collated initially according to the geographical location of the general practice in which each nurse was employed. The responses included many articulate comments which I transcribed in full for later analysis. After the results had been collated and analyzed I wrote a paper *Practice Nursing in Canterbury: a preliminary report of the results of a questionnaire distributed to Practice Nurses in September 1993* (Appendix D). A copy of this report was sent to the local committee of the Practice Nurse Division early in 1994. I did not receive a formal response from the committee. The report was useful mainly as a way of informing practice nurses who agreed to participate further in the study about the outcomes of the survey. I inserted another notice in the newsletter

distributed by the Canterbury Practice Nurse Division to thank those nurses who had responded to the questionnaire, and inform them that the results had been made available to the Canterbury Practice Nurse Division.

Before I arranged visits to general practices I spoke to a general practitioner who was an acquaintance and asked him about strategies which might be appropriate when contacting other general practitioners about participation in this research. At his suggestion, I wrote to the Chairperson of the Canterbury Branch of the Royal New Zealand College of General Practitioners, informing him about my research. I enclosed a copy of the questionnaire which had been sent to practice nurses. My letter was passed to the Postgraduate Tutor in General Practice, Dr. Holland, who replied to me in October 1993 (Appendix E). He wished me well and warned me of the sensitivity surrounding the issue of practice nursing, mentioning specifically the challenges posed to doctors by the competitive provision of primary health care services. He also suggested I contact the editor of the newsletter of the Canterbury Faculty of the College, to include a notice in this newsletter. The notice I prepared informed general practitioners about the study, and sought their co-operation in the fieldwork component of the research. In this notice I explained that I was a registered nurse, and would be prepared to assist if necessary within the practices, rather than distract the nurses from their work. This addressed one of the concerns articulated by Dr. Holland in his letter (Appendix E). There were no replies to, or comments on, this notice.

In April 1994 I attended the New Zealand Nurses' Organisation National Conference of Practice Nurses in Auckland. This was an opportunity to find out about the concerns of practice nurses at a national level, and exposed me to some innovative practices of practice nurses, such as the services offered at the Eketahuna Health Centre by two practice nurses who are supported by doctors at Pahiatua, twenty-six kilometres away. Although many of the nurses who attended this conference expressed polite interest in my research, I did not find it easy to establish further contacts with practice nurses. Attendance

at the conference also gave me a better understanding of the interest and involvement of pharmaceutical companies in practice nursing, a field which is not explored in any detail in this thesis, but is a possible area for future research.

Twenty-four practice nurses indicated in their responses to the questionnaire that they would be willing to participate in other aspects of the study. These nurses were employed in practices which were situated in a variety of geographical locations. I approached each nurse in the way she[13] had suggested, usually by telephone. This first contact involved a discussion of how they might be involved in either the fieldwork or interview components of the study. Some nurses withdrew for various reasons. These initial conversations with the practice nurses who had indicated that they were prepared to be approached directly were very useful in assessing where I would like to do participant observation. My interest was in locating myself in a variety of urban and rural practices with different types of patients.

I wrote to seven general practitioners to ask permission to participate in their general practices. Although all the doctors gave verbal permission to the nurses they employed, only one replied directly to me. As a result of these approaches to general practitioners I visited seven general practices during 1994. Two of these practices were located in the inner city of Christchurch. These practices were quite different, one could be classed as upmarket - I walked into an environment suffused with the sound of classical music and the smell of plunger coffee - and the other practice targeted lower income

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[13] While practice nurses are not necessarily female, all the nurses included in this study are women. All the responses to the postal questionnaire were from females. Subsequently I was informed of two male practice nurses who working in Canterbury. One male nurse was working part-time temporarily, another male nurse was working in an After Hours Surgery and was described as "more like a manager than a nurse" by members of the Canterbury Practice Nurse Division (Meeting notes,25.7.95).

families. I visited two suburban practices, one in east Christchurch and one in north west Christchurch. While these suburban practices were both predominantly "family" practices, many of the families who visited the east Christchurch practice were from a lower socio-economic grouping than most of the families who used the practice in north west Christchurch. I visited two rural practices with different geographical attributes. I was also invited to visit a suburban practice in Ashburton, a large mid Canterbury town. I spent at least two days in most of these practices, working predominantly alongside practice nurses. I was involved in a variety of tasks, from cutting disposable pads in half and autoclaving instruments, to testing urine to confirm pregnancy and helping with ear syringing. I was driven around winding roads by a practice nurse who also works as a domiciliary nurse in a rural practice, accompanying her on her visits to people with a range of needs.

During the period of informal participation in selected general practices I began to conduct indepth interviews with practice nurses, interviewing seven practice nurses as well as the nurses in the practices in which I was doing fieldwork. I also meet with an Organiser from the local branch of the New Zealand Nurses' Organisation. These interviews were taped and the transcript returned to the participants for alterations and approval before being analyzed and included as quotations in this thesis. The nurses made very few alterations. The interviews were conducted in various places chosen by each nurse. One nurse came to my office at university, and another nurse asked me to come to the general practice where she worked. Most nurses preferred to be interviewed in their homes.

In August 1994 I attended an interesting meeting called by several nurses who were part of a steering committee set up to liaise with members of the Pegasus Medical Group[14]. Although I had heard that this meeting was to

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[14] The Pegasus Medical Group is an Independent Practice Association. The idea behind the formation of such an organisation is that it would act as negotiating agent in the

take place from a source other than a practice nurse, when I approached the Chairperson of the Canterbury Practice Nurse Division for permission to attend she encouraged me to do so.

In April 1995 I was approached by the Postgraduate Tutor of Practice Nursing to discuss the outcomes of this study with practice nurses in the form of a seminar. In June I spoke to a meeting of practice nurses about issues surrounding physical space in general practice for nurses, and the contradictory notions of combining "care" and "doing business". As I had previously worked in hospitals with many of these nurses, I found presenting such a seminar challenging. It highlighted the complexity involved in being both nurse and researcher, one of the methodological issues discussed in Chapter Two.

1.6 The structure of the thesis

Methodological issues are a core concern throughout this thesis, but are addressed most specifically in Chapter Two. In this chapter I reflect on the extent to which the realities of the actual research process challenged my initial ideas about doing feminist research. Nicola Armstrong (1993) has spoken about the "slippage"[15] she experienced between the ideals of feminist research articulated in published texts, and the actual process of her research into homebased telework. I also experienced this sense of "slippage". In my case this was complicated by a sense of ambivalence about the ways in which I was simultaneously nurse and researcher. Given my professional identity as

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contract negotiation between general practitioners and the regional health authorities. The Pegasus Medical Group came into existence in March 1993, and has a membership of nearly 200 (Manchester,1995:14) general practitioners in Canterbury.

[15] "Slippage" was the term included in the title of a seminar given by Nicola Armstrong at Canterbury University on 9th August, 1994. The seminar was based on her paper *Sex, Lives and Audiotape: Problems for Feminist Research*, 1993.

a nurse, constructing myself as sociological analyst rather than as nurse was sometimes a challenge.

The notion of space - sites, location, and boundaries, is used in Chapter Three to explore the concept of the "place of" the practice nurse. Feminist geographers' understandings of the social implications of physical space, especially those of Louise Johnson (1992,1994) and Geraldine Pratt and Susan Hanson (1994), have largely informed this analysis of the relational positioning of practice nurses. Lawrence Berg's (1994:257) notion of analysing places as "sites of contested discourses" was especially useful when sifting through the complex social processes which intersect individual general practices. My interest is not in the documentation of nurses' subordination but in the strategies which they use to position themselves as members of a primary health care team and as collaborators rather than subordinates in their relations with doctors. This chapter explores the relation between these social positions and the distribution of physical space between health professionals within general practice.

Practice nurses daily negotiate the tensions between "doing" professional care and the commercial interests of the practice as a small business, a situation which contributes to the contradictory and ambiguous feelings expressed by some of the nurses. The business components of the "care" provided by practice nurses is the focus of Chapter Four. Understandings of the notion of "care" drawn from the work of Nicky James (1992) and Joan Tronto (1989) are used together with Arlie Hochschild's (1983) recognition of "care" as a part of "good business", to show how the work of practice nurses bridges the gap between the patient/client, the health professional in the private sphere, and the regional health authorities. I suggest practice nurses care "for" both patients/clients and the general practitioner for whom they work, and also care "about" health education and illness prevention, as well as "about" the business of general practice. In the coupling of notions of "care", practice nurses tend to be continually reconstituted as willing voluntary "carers". This

contrasts with the desire for "professional" status expressed by most practice nurses.

This study of the way practice nurses work suggests that any simple assumptions about practice nurses as doctors' "subordinates" is inappropriate. Chapter Five focuses on occupational strategies actively engaged in by many of the practice nurses who participated in this study. This chapter discusses the ways in which discursive notions of "teamwork" and "collegiality" are being utilised to emphasise the complementary nature of the work performed by practice nurses and general practitioners. I discuss the analysis of current nursing challenges to medicine offered by Anne Witz (1994), and also the notion of "a system" of professions developed by Andrew Abbott (1981,1988). My research suggests that most practice nurses want a closer association with medicine in the sense of an inclusive nurse/doctor "team" situated within general practices. This is in contrast to the pursuit of a closer association with other community nursing teams, and nursing philosophies which tend to emphasise "enhanced" (Witz,1994) nursing roles based on "partnerships" or "collaborative relationships" (Allen,1992:19) with patients/clients. At the same time, some practice nurses are constructing practice nursing as a nursing "specialty".

The final chapter reflects on the complex positioning of practice nurses. It includes attention to communication, facilitation and organisation as crucial aspects of nursing practice. While not denying the constraints on practice nurses, as publicly funded employees historically constructed as "assistants" (Thomson,1978:84; Collins,1996:84), the focus is on practice nurses as strategic actors who construct their professional identity through the utilisation of discourses of "collegiality" and "teamwork". This study attempts to make practice nurses visible and explore their agency as health professionals. It indicates how the "professional" and gendered work of practice nurses is significant to both the businesses of general practice and the management of publicly funded primary health care.

CHAPTER TWO

SLIPPAGE AND AMBIVALENCE: THE COMPLEXITIES OF FEMINIST RESEARCH PRACTICE

This chapter focuses on the methodological concerns which were a core issue throughout the research process and provides a more detailed discussion of the components of the research strategies outlined in the previous chapter. I reflect on the extent to which the realities of the actual research process challenged my ideas about doing feminist research. I also reflect on how my position as researcher and former nurse was central to the research process and at the same time highlighted the complexity of feminist research practice.

2.1 Feminist social research

I embarked on this research with a firm and enthusiastic commitment to feminist theory and research practice. Feminist researchers see social research as a social process - one which demands self-consciousness and self-criticism on the part of the researcher (Du Plessis,1993:6). Rather than following a distinct set of specifically feminist practices, feminists engage in various research strategies in ways which are shaped by feminist theory, particularly feminist critiques of the inequalities in the distribution of power. As I began the research I sought to establish a dialogue with the practice nurses, seeking and taking advice, and feeding back information and analysis - strategies directed at increasing the control of research participants. I expected that this "process would become part of the product" (Reinharz,1992:212).

Yet as I articulated my orientation to this research to the practice nurses, I felt vaguely uncomfortable. Like Sandra Harding (1987:2), I was still unclear about the features of the **best** feminist social inquiry. How could I be confident that the strategies I would use would be "empowering" for those participating in this research? How could my research be research "for" women, when I was still

deliberating over relevant theory? Coping with difference, not only differences between the women we are researching, but also differences between feminist theorists and researchers, is a challenge for contemporary feminism. Nicola Armstrong, in a discussion of some of the problems and potential of feminist research associated with her research into homebased telework in New Zealand, describes her response to the growing debate about what constitutes feminist research methods in this way:

> I perceive my research project as coming out of, and responding to, what has been defined as "feminist research" at the same time as I would argue the analyses and politics which inform this perspective are contested to such a degree that this single description may well be unable to encompass its diversity (1993:8).

Nicola Armstrong (1993) has reflected on the "slippage"[1] between the texts describing the ideals of feminist research and her actual experiences as a researcher. I too experienced this "slippage", complicated by a sense of ambivalence about the ways in which I was simultaneously nurse and researcher.

While I had initially been enthusiastic about doing research in ways which empowered participants, during the first phase of this research I realised the significance of the power inequalities inherent in any research process. To obtain access and to initiate rapport with practice nurses I used the fact that I am, like them, a registered nurse. As I negotiated with them about their participation in this research, I could not help wondering **how** informed that consent could be. When I trained as a nurse in the late 1960s the Christchurch School of Nursing operated with a hierarchal teaching model consistent with the position of nursing in the medical division of labour. Nursing sisters taught us practical nursing techniques while medical doctors, usually consultants, lectured in their "expert" areas. The doctors gave us information to a level they thought

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"Slippage" was the ream included in the title of a seminar given by Nicola Armstrong at Canterbury University on 9th August, 1994, based on her paper *Sex, Lives and Audiotape: Problems for Feminist Research*, 1993.

appropriate for our involvement as nurses. Nursing educators did not encourage us to challenge, or pose questions. We were trained to follow orders, and did so. I was aware that most of the practice nurses had been trained as I had been and that this training could affect how they responded to my request for informed consent. Would they feel free to pose questions about the research? Had I given them information which would enable them to make a choice about their participation?

Feminist epistemologies tend to assume that knowledge is shaped by the social position of those who produce it (Harding,1987:9) - and this includes feminist researchers who are also positioned in sets of social relations which shape the knowledge they produce. Attending to my positioning generated acute self-consciousness and self-criticism throughout the research - self assessment which at times led to a kind of creeping paralysis. I was reminded that feminists acknowledge the emotional aspects of the research process - this is an element of research not directly addressed in most sociology text books.

2.2 The survey of practice nurses

I decided to begin this research with a survey. My interest in constructing this research as "serious" and "legitimate" led me to consider using a research strategy which many feminist researchers have subjected to critical scrutiny. Quantitative methods, such as the social survey, have been criticised for transforming individuals into cyphers, misrepresenting or obscuring women's experiences (Graham:1983:135). Feminist researchers like Dorothy Smith (1990) advocate a "sociology for women" in which feminist research practice always preserves the presence of women as active and experiencing "subjects" who can express their experiences fully and in their own terms, rather than transforming them into "objects" of study.

Nevertheless, feminist researchers Jayaratne and Stewart (1991) have suggested that it is timely and appropriate for feminist researchers to use research designs which combine quantitative and qualitative methods. They argue that this:

> ... should result in a more powerful research product, that is, one which not only effectively tests theory but also is convincing (1991:102).

They suggest a multi-layered or multi-faceted understanding of a particular field of inquiry, arguing that this facilitates what is sometimes called "triangulation". What feminist researchers have to be aware of, and address, are the problems associated with each approach (Jayaratne and Stewart,1991:102).

The practice nurses with whom I had initial contact assumed I would be doing a social survey and spoke to me of the need to obtain some demographic data. This confirmed my belief that most nurses have assumptions about research which are shaped by scientific models of credibility. Interestingly, the need for demographic data about themselves was spoken about in the same breath as they expressed their dismay at discovering that their names were not recorded with the former Department of Health, as part of the procedures by which subsidies were paid to the general practitioners who employed them. The former Department of Health had recorded the names of the general practitioners to whom the subsidies were paid, not the nurses who were paid via the subsidies. The only source of names of practice nurses in Canterbury was the mailing list used by the postgraduate tutor, who helpfully allowed me access to her records. The New Zealand Nurses' Organisation was not an accurate source of information as not all practice nurses belong to this professional organisation.

I saw the design of a survey of practice nurses as an opportunity to work with both the local committee and the postgraduate tutor. I hoped to establish a network through which information could be collected and disseminated, as well as enable members of the Canterbury Practice Nurse Division to formulate questions to which they would like some answers. While the questionnaire could be totally anonymous, I saw the survey as a means whereby practice nurses who were willing to be interviewed, or who could facilitate my access to participant observation in the practices in which they worked, could indicate their willingness to participate in other phases of the research.

The Chairperson of the Canterbury Practice Nurse Division responded to the discussion document outlining my research agenda in this way:

> *We are very excited by your proposal and are willing to help in anyway we can. We have established a sub-committee to work with you as needed in advisory etc capacity...we look forward to a fruitful and rewarding 2 years working with you on this research.*

This was just the sort of response for which I had hoped. I enjoyed the social contact with the sub-committee and I added the questions they proposed to the questionnaire. Following this collaboration, the postgraduate tutor, who was a member of this sub-committee, devised her own questionnaire directed at finding out what topics practice nurses would like incorporated into her programme. This questionnaire was sent to the practice nurses the week before I distributed the questionnaire we had developed in the sub-committee. Two weeks before the questionnaire for this study was posted the New Zealand Nurses' Organisation had also sent out a questionnaire to practice nurses. As a result, the questionnaire for this study was the third the practice nurses were asked to complete in a month. This had a significant impact on the response rate. In the circumstances it was probably remarkable that 52% of those surveyed returned completed questionnaires.

The nurses with whom I worked on the research advisory sub-committee tended to be women who were busy balancing work and domestic responsibilities. In the limited time we were able to spend together I began to realise that they tended to think that my ***published research*** was going to show conclusively that they were ***invaluable*** members of the practices in which they worked. My strategies for gaining rapport seemed to be interpreted by the nurses as unconditional affirmation of their position. Like Judith Stacey (1991:113) I found myself wondering whether the appearance of equality with my subjects masked a subtle form of exploitation. But how could I be both a critical analyst and an advocate for practice nurses?

My contact with the nurses produced a nostalgic desire to work **with** the nurses, not just gather information about their position. I recognised that the issue I was confronting as a researcher was one of partiality and positioning. I was uneasy about my relationship to the discipline of sociology just as the practice nurses tended to express unease about their position in general practice. This was complicated further by my position as a registered nurse who had been out of the world of nursing for nearly twenty years. I knew theoretically that most feminists recognise that the knowledge they produce is also likely to be "partial" (Abbott and Wallace,1990:4) and that complete collaboration with participants is unattainable (Armstrong,1993:6). I had to think carefully about the baggage I had brought to the research, and what impact that was having on the way I was conducting the research.

My discomfort was obvious as I wrote the preliminary report of the results of the questionnaire, taking care that I strategically represented the findings as completely as I could, but excluded material which might have an impact on the fieldwork in general practices. This was shaped not only by my perceptions of the responses of practice nurses, but also by how general practitioners might respond to arguments and analysis included in this report.

I was disappointed that I did not receive a reply of any kind to the preliminary report from the Canterbury Practice Nurse Division. In answer to my questioning, two practice nurses on separate occasions both mentioned a particular comment included in the report:

> *[I dislike] the phone - bombarded with absolute dipsticks, in inner-city we get a lot a "subbies" - the real low life types which can be very demanding and difficult to handle.*
> (Questionnaire response from nurse employed in inner city practice).

These nurses expressed concern about a nurse making what they saw as derogatory remarks about one of their patients. They implied that they were surprised that I as a nurse could incorporate such a comment into a report. Nurses are not supposed to express such judgements to the public, nurses are

supposed to be selfless and positive about clients. I tried to distance myself by explaining to both these nurses that my approach to practice nursing was sociological rather than the approach of a professional nurse. Whichever way I phrased it this sounded as if I was attempting to construct some superior position from which to view them as practice nurses and I abandoned this strategy. I was learning to negotiate the complex dynamics of my position as sociologist and registered nurse.

While I did not receive positive feedback from the Canterbury Practice Nurse Division on the preliminary report, the questionnaire proved more than just a tool to initiate the research. I received 122 replies, from 52% of the practice nurses in Canterbury to whom questionnaires had been sent. The completed questionnaires provided rich and detailed information on a range of different issues. The replies highlighted the contrasting situations of practice nurses and the wide variety of work in which they were involved. Any fleeting thoughts I may have had as to my role in "consciousness raising" among practice nurses were rapidly dispelled by practice nurses' responses to the open-ended questions. Some practice nurses gave a critical analysis of their work situation, as indicated by the response from this nurse:

> *...unless they want to reprimand me about some negative aspect of the job there's no positive feedback. I feel (even after nine years) that I'm just there to do as they bid, that they don't even think I've got a status of my own and can decision make on my own. They don't value my work, the receptionists have a more even footing with the doctors than I do. I even wonder if they are threatened by my knowledge and endeavour to put me down to keep me from "taking over". Come the revolution...!*
> (Questionnaire response from nurse employed in suburban practice).

2.3 Insider and outsider: informal participation in general practices

The second stage of the research was to participate in general practices on an informal basis. Twenty-four nurses indicated on their questionnaires that they would be willing to participate further in the research. Fortunately they were

located in a wide range of practices. I contacted all the nurses who had written their names on the questionnaires - two of the nurses had written directly to me, offering to be interviewed, and another wrote inviting me to visit her practice. At the initial approach I discussed the possibilities of involvement with each nurse. Most of the nurses left it to me to decide whether it would be more useful to visit their practice, or meet them for an interview. In this way I was able to choose to visit practices from a range of geographical locations. During the final stages of the fieldwork, I contacted two practice nurses who had not offered their names but who were working in ways which I wanted to include in my study to cover a wider range of workplace experiences. They were not known to me personally, but they both agreed to my visiting their respective practices.

My initial conversations with these practice nurses gave me a sense of how each nurse felt about her work. It was also useful in assessing the response I might get from her employing general practitioner. It allowed some nurses to withdraw from further participation in the research. One nurse worked at the medical centre which my family attended. We both felt it would inappropriate for her to participate. Another nurse felt she did not have enough to contribute as she worked part-time for few hours. Another nurse was having a baby and needed to leave sooner than I could attend the practice in which she was employed.

I visited seven general practices in total. Two were in rural settings with different geographical attributes, one situated on a peninsula with steep, winding roads, and another on the Canterbury plains. I visited two suburban practices in Christchurch located in communities of contrasting socio-economic status, and one in a large mid Canterbury town. The two inner city practices differed with respect to clientele and atmosphere. Every general practice was differently organised and as a result the nurses managed their work in different ways. One rural practice nurse was also the domiciliary nurse for the district; another rural practice nurse spent one day a week as a health promotion officer; the suburban nurses tended to work more with younger children and their caregivers and with

elderly clients. The inner city practices differed from one another in that one was in the centre of town and dealt mainly with people who found it convenient to attend during business working hours, while the other practice attracted young families as it tried to keep its services affordable. Common to all the practices was the impact of general practice as a private business on the way "care" was provided and this started to become a more important focus for the research. I became particularly interested in the place of the practice nurse salary subsidy in the provision of primary health care through privately owned general practices.

It was during the days of fieldwork in general practice that I experienced the most ambivalence about this research. I found that I would enter the building fingering my nursing badge in my pocket, never sure when and whether I should pin it on. I always asked the practice nurse whether she would like me to wear it, and every nurse indicated that I should wear it and identify myself as a registered nurse. We both knew that if I wore the badge this would facilitate my access to situations in which I could observe the practice nurse at work. But I was aware that by wearing my badge I was suggesting that I was a practising nurse and this seemed an inappropriate identity, despite the fact that I have an up-to-date practising certificate.

When a general practitioner suddenly asked me which wound cleanser was used in most general practices I had to say "I could not really say". This made me feel shabby - my credibility as a registered nurse had plummeted. As a social researcher I had been looking at the social relations in the general practices I had visited. Most practice nurses tended to explain their actions to me, giving reasons why they did procedures a certain way. Anxious to avoid nurses feeling that my presence as researcher **and** nurse meant that I was evaluating their nursing **practice**, I tended not to concentrate on the details of actual nursing procedure such as which cleanser was used to clean wounds. As a registered nurse this is precisely what I should have been doing. I had used the fact that I was a registered nurse as a lever to gain access to the general practices and to

get access to interactions between nurses and patients but this was a "flawed identity". I had a real sense of being "found out".

I had to realise that I could not expect that my position as a registered nurse would mean that I would be trusted by the practice nurses. Nor could I expect that my observations on the position of nurses in general practice would be welcome. I had to acknowledge that while we shared many experiences, my interest in feminist theory and research strategies generated differences between us. While I might endeavour to "stand on the same critical plane as the researched" (Harding,1987:9), and ideally would have liked to acknowledge positions of difference, this was not always possible.

The issue of immunisation was one which I had had to confront on a personal level and as I proceeded with the research I found that my position on this matter would be at odds with many of the practice nurses who participated in this study. Immunisation was a significant part of the practice nurses' work and they rarely gave any indication that they thought that the programme was anything other than vitally necessary for all children.

I was aware that the training I had received and the training of most practice nurses had also encouraged assumptions of a moral nature - we were taught to think of certain behaviour "good" and other behaviour "bad"[2] - the lines were sharply drawn and influenced by the dominant discourses of the 1960s. Caregivers who chose not to immunise their children were sometimes talked about by practice nurses in an impatient, derogatory fashion. To openly acknowledge that my son had been left with neurological damage arising out of a reaction from an immunisation, and that I would not let my daughters be immunised as a result, may have invited defensive reaction rather than rapport.

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[2] For further discussion of the tendency of nurses to engage in this form of stereotyping see Carl May, 1992, "Nursing work, nurses' knowledge, and the subjectification of the patient" in *Sociology of Health and Illness* Vol. 14 No. 4 p 475.

This was an issue on which I was unavoidably partial from the beginning, but sensitive to the impact of difference on my relationship with practice nurses. I answered honestly when asked by one of the nurses what had happened to my son, but I chose my words carefully.

At the same time, I always consciously kept busy in the practices. In this way I "earned" my participation and worked alongside those I was studying. I filed notes, cleaned equipment, tested urine for pregnancy, and reassured patients. I had not realised how easy it would be to reassume the position of nurse. In addition, as I did this nursing work I discovered that, despite my new position as "researcher", I was still slightly in awe of medical doctors.

2.4 The research relationship with general practitioners

My suspicion that my presence was sometimes unwelcome was exacerbated by my contact with the general practitioners. Early in the research I had approached a general practitioner I knew and spoke to him about strategies I might use when approaching other general practitioners about participation in the research. After I had sent him an outline of this proposed study, this doctor wrote to me:

> *I have discussed your project with (another GP) and he also thinks it very worthwhile.*

He assumed the research would have an excellent outcome for general practitioners because I could not help but make a convincing argument to justify payment of subsidies to general practitioners.

At his suggestion I wrote to the Chairman of the Canterbury Branch, Royal New Zealand College of General Practitioners, asking for their consent to my participant observation in selected general practices. I received a letter (Appendix E) from the Postgraduate Tutor of General Practice who had had my letter referred to him. The tone of this letter was not so positive. He stressed the difficulties I might encounter gaining access to general practices:

> *...this is likely to be a sensitive issue, particularly in the current*

climate. You may find some practices reluctant to spare nurses at this stage. Practice nurses are a valued and busy part of most practices. It will be essential that Nurses not be distracted from patient care while helping with the research and so you may find practices reluctant to spare Nurses during work hours. However your proposal to participate yourself in Practices may be seen as compensation....Do always bear in mind there is a sense in which the Practice Nurses could operate in competition with GPs and that this will influence the response you receive from GPs.

The letter illustrates the tensions between practice nurses and general practitioners. Practice nurses are a valued part of general practice, but at another level they can be seen as potential competitors, capable of providing primary health care as "independent" practitioners.

Although all the doctors gave verbal permission to the nurses they employed, only one of seven general practitioners replied to my letters asking for permission to informally participate in their practices. The doctor at the first practice in which I did participant observation, a woman in a rural practice, reluctantly shook my outstretched hand, and thereafter tended to ignore me, making minimal eye contact. When she spoke quite sharply to the nurse about something she was annoyed about, the nurse excused her behaviour saying she did get upset at times, not at the nurse but at certain inefficiencies, and then, perhaps feeling disloyal, the nurse added that she was such a good doctor. Another doctor, a young woman from an inner city practice, when introduced to me by the nurse, sternly warned me not to speak about any of the patients I saw attend the practice - her manner was so abrupt and authoritative I found myself backing against the treatment room bench. A third male doctor in a suburban practice asked me what I was writing my MA Thesis on and when I replied "Practice nurses", he laughed derisively "On J____? A Thesis on J____?" Apart from one male doctor, the other doctors were simply not interested in me or my thesis and ignored my presence.

The actual experience of informal participation in general practices and the

wearing of my badge, made it easy to succumb to the social relations of authority within which practice nurses have to work. While I had been exposed to literature on multiplicity of selves I found myself at times assuming the unitary nurse self I had occupied in the late 1960s. Michel Foucault (1982:221) has suggested that what is often referred to as a "self" is better understood as shifting or fragmented selves which we reconstruct through internal surveillance and recognition of how we wish to be. This is defined for us by discourses which are often contradictory, and deployed differently in different contexts (Foucault,1982:221). My deployment of the resources of empathy and connection (Stacey,1991:102) had in some respects resulted in an "over-identification" (Neale,1996:3) with the nurses who participated in the study.

2.5 Gender: enabling or constraining?

Although the nurses were all female, most of the doctors with whom I had contact were also female. The female doctors were in positions usually associated with men and sometimes exhibited the personal characteristics we usually attribute to males rather than females. This poses a challenge for sociologists who see gender as useful for understanding nursing. In general practice it is not a clear case of female nurses and male doctors. Nurses and doctors often share the same gender, but are positioned differently as health professionals, and as employer and employee.

The observations in this study suggest that, in some ways, relations with general practitioners may be less empowering of practice nurses when doctors are female. If a woman client wanted a female smear-taker and the general practitioner was male, then the female nurse was able to do this, as this nurse indicates:

> *What I do is I keep a record in the computer of people who have smears due and every month I send out a note. It says "if you've never had an abnormal smear then you've got a choice of a doctor or a nurse doing it" and then they have a choice, but any abnormal ones in the past the doctor insists on doing it which is... then they ring in and say "well I want the nurse to do it or "I want the doctor".*
> (Interview with nurse employed in suburban practice).

The relationship of authority and the role of doctors in diagnosis preclude the possibility of this nurse performing smears when there has previously been an abnormal result, regardless of some patient's preference for a female smear taker. If the general practitioner was female, however, the doctor might conduct all the smears. The gender of doctors therefore has an interesting impact on the work practice nurses are allocated, but it is not the only factor affecting the situation of this group of health professionals. Like Bev James (1986:18) my research experience prompted a critical examination of my assumptions about gender. There were other forces at play which I needed to understand and try to explain.

2.6 The process of interviewing

I completed eight interviews during the final stage of the research, including one with an advisor from the New Zealand Nurses' Organisation. The interviews were usually conducted at the nurse's home where I was always made welcome. Two nurses asked me to interview them in their office. I attempted to make the interviews as unstructured and as informal as possible, but I was aware that each nurse politely waited for me to begin with a question.

I was slightly thrown at an interview when the practice nurse asked me to come on a certain morning because her husband would be home to mind the baby, and on beginning the interview she told me her husband was the general practitioner for whom she had worked - he was present in the background and I felt that what we could discuss was restricted by his presence. When he left to take the baby for a walk, I did ask questions about the subsidy provision and got answers which contradicted some earlier assertions the nurse had made, but I did not transcribe the tape verbatim. Rather, I put the words into the third person. I anticipated that her husband would probably be interested in the material I sent back to her. This was confirmed as she enclosed a note thanking me for the copy of the discussion document saying she and her husband had found it *very interesting!!!* (her exclamation marks).

My attempts to focus the interviews around the business aspects of general practice met with some resistance. The nurses did not want to spend time discussing this aspect of their work situation. One of the nurses was obviously uncomfortable about the extra work, in terms of immunisation recalls, she did from her home. Her discomfort was exacerbated by the presence of her husband who had come into the kitchen for a cup of tea, and whose wry comment that she did not get paid for it suggested some conflict over the time involved in this home based work.

All the nurses were anxious that I "knew" that practice nursing was a vital part of general practice, as these nurses indicate:

> *My own perception is that even if the subsidy was totally removed the doctors would HAVE to continue employing virtually a full-time nurse unless they were going to restructure things and I don't think they want to do that.*
> (Interview with nurse employed in a suburban practice).

> *They know they need us and they (the doctors) have both said that.*
> (Interview with nurse employed in a rural practice).

The nurses seemed eager to tell me about their usefulness to their employers, and to the communities in which their practices were located. Indicative of this enthusiasm was the letter one nurse included when she returned the corrected transcript of our interview. In this letter she emphasised that she really did take her job very seriously, despite her sense that the transcript suggested that she did not always do so. Anxious that her comments indicated "teamwork" which was less than ideal, she wrote that she knew she was lucky to work for such good doctors. Her comments on the importance of "teamwork" were similar to those made by most of the nurses I interviewed. During the interviews it became clear that the emphasis on "teamwork" was not only an ideal concept referred to in many of the responses to the questionnaire, but was also a significant component of the discursive strategies used to redefine the place of nurses in general practice. This became another important focus for the research.

My decision not to embark on formal interviews with general practitioners who employed practice nurses was based on several factors, including the way some of the nurses responded to information about the study. While most practice nurses were delighted that someone was interested in their work, some nurses expressed concern that authoritative medical voices could diminish the impact of their account of their work in general practice. As a registered nurse as well as researcher, I felt that this was a relevant concern. On reflection, I realise that my tendency to use my qualifications and gender as resources to "pass" in general practice undermined my credibility as researcher in interactions with general practitioners. This has inevitably had an effect on the analysis of practice nursing offered in this thesis.

2.7 Concluding reflections

Understandings gathered through the fieldwork for this study tended to emphasise issues which were initially raised through information gathered from the responses to the questionnaire. In this respect, the use of a combination of methods has enabled me to:

> ... capture a more complete, holistic, and contextual portrayal of practice nursing (Jick, quoted in Jayaratne and Stewart,1991:91).

While the decision to use a range of research methods resulted in valuable information, the distribution of the type of information was different than I had expected from my reading of specific feminist criticisms. Rather than the survey method "objectifying" the respondents, the inclusion of open-ended questions resulted in articulate, sometimes critical, responses from practice nurses. The replies to the survey gave me a broad picture of practice nursing which was very useful to draw upon as I proceeded with the research. In contrast to the range of information gathered through responses to the questionnaire, the practice nurses who had agreed to be interviewed rarely expressed concerns about their work or their clientele. I was able to use the time in general practices to explore these further.

This study has placed practice nurses at the centre of analysis, rather than general practitioners who are usually assumed to be the main occupational actors in primary health care. It is limited in terms of attention to issues relating to ethnicity and primary health care delivery. While the patients they served were not exclusively Pakeha, the research strategy which focused on practice nurses rather than patients contributed to a diminished focus on ethnic differences since the nurses were overwhelmingly Pakeha. As I will discuss in Chapter Three, the medical "front" presented by most practice nurses is often a reflection of the dominant culture. This raises questions about the appropriateness of the place of general practice as the predominant provider of primary health care services for all New Zealanders. However, this is a situationally specific study restricted to Canterbury, and can not be generalised to other areas.

Although I had begun with idealistic aspirations of feminist collaboration with practice nurses, I found the actualization of these ideals was at times quite problematic. As both "insider" and "outsider" I was careful about the information offered to "obtain consent". I was also careful about how I constructed the preliminary documentation of results. To date, I have not received much response to the preliminary discussion document which outlined the survey results. Despite my commitment to participatory research, I have had to accept that feminist collaboration can only ever be partial. Nicola Armstrong (1993) and Judith Stacey (1991) both acknowledge that the researcher has the final word on what material is modified, and what is actually documented. In this respect, partiality on the part of the participants is a necessary component of any feminist research which seeks to affect women's lives in a positive manner. As Judith Stacey (1991) has provocatively argued, the power inequalities inherent in any research may in fact be exacerbated through strategies of collaboration with women who may share information, the use of which they can not control.

CHAPTER THREE

A ROOM OF HER OWN? PLACE, SPACE, AND PRACTICE NURSING

> **"Places are constructed through social processes and, so too, social relations are constructed through place"**
> (Pratt and Hansen,1994:25).

> *"No room to call one's own"*
> (Questionnaire response from nurse employed at a suburban practice).

Through their replies to the questionnaire the nurses had given me a broad picture of practice nursing, and some understanding of existing tensions. As I visited different general practices I was able to observe practice nurses at work. Practice nurses' responses to the open ended questions had included frequent comments about being very busy, and needing more time. These pressures often arose out of practice nurses' positions as the *"go-between"*. As one nurse wrote:

> *(I dislike) the dual role of being practitioner and "helpmate" to the GP -always the go-between the GP/ receptionist/ patient etc., ie demands coming from all angles; constant interruptions by telephone and doctors needing something; sometimes too wide a variety of things expected of us eg. stocking urine jars - counselling depressed patients - counting the linen - organising huge volume of educational material - sorting out appointments with specialists.*
> (Questionnaire response from practice nurse employed in a suburban practice).

This nurse describes the complexity of her working relationships within general practice. She is expected to be "practitioner" of nursing tasks, yet she is constantly interrupted by telephone, and doctors who "need something". Although she is expected to be professional "helpmate" to the doctor, she also counts the linen and stocks urine jars. This nurse's description of the different skills needed under constant pressure matches my own observations of practice nurses at work in general practices.

The work practice nurses do is similar in nature to domestic labour in that it is not easily measurable nor always even visible, and the content varies greatly from day to day. There are no formal recognisable "outcomes" for practice nursing, even immunisation rates are discussed in terms of rates for the practice rather than ascribed to the practice nurses who usually give the immunisations[1]. Yet practice nurses, like domestic workers in a private household, occupy a crucial positioning in the operation of general practice. This was the way one practice nurse described it:

> *We are the cog in the wheel that holds the place together - when we are not here the place falls apart.*
> (Practice nurse employed in suburban practice; during informal participation).

In this chapter I will use spatial metaphors - sites, location, and boundaries - to explore "the place of" the practice nurse, within the various sites of general practice, and the primary health care "team". Throughout the research process practice nurses commented frequently on the *lack of space* they have available to them, especially the space necessary to offer privacy to patients/clients consulting them as health professionals. "Lack of space" seems to capture the constraints on practice nurses - a containment which is both literal and metaphorical.

3.1 The social implications of physical space

The social implications of physical space have been discussed by a number of feminist geographers (Johnson,1994,1992; Pratt and Hanson,1994; Milroy and Wismer,1994). They have argued that the allocation of physical space is an expression of a highly structured and inequitable society (Johnson, 1992:6). Louise Johnson writes of the "potential and need to incorporate spatial

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[1] For example, an article in the *Christchurch Star* (Walker,1994:2) reports Christchurch General Practitioners as joining forces with the Plunket Society in a project aiming to improve the levels of immunisation in the city. The centrality of practice nurses, who perform the immunisations and understand them to be their responsibility, is not acknowledged.

differentiation into studies of bodies, language, women and culture" (1994:108). She recognises the complexity of trying to interpret interactions with others and the geography this creates, while at the same time acknowledging the power dynamics of categories such as "class, sex, race, ethnicity, our institutional and sexual positions" (Johnson,1994:111). All social relations can be seen as spatial, as taking place within particular physical contexts whose attributes matter (Kobayashi and Peake,1994:239).

The notion of a place as a "site of contested discourses" (Berg,1994:257) is useful when considering general practices as sites intersected by complex social processes, both from within the practice itself and from outside, processes which both challenge and sustain the social relations of those who work there. This orientation to general practices as sites allows me to look at the ways in which the practice nurses work without eclipsing the variety and difference I encountered in different general practices (Pratt and Hansen,1994:5).

This chapter will focus particularly on the gendered expectations of nurses and the people with whom they interact. My initial attempts to explain these in terms of oppositions such as "traditional" and "professional", and "public" and "private" spheres, did not capture the complexity of the ways in which nurses are positioned. This analysis of practice nursing demonstrates that these spheres/spaces are not separate but overlap, connecting at various points at differing sites, and are therefore only loosely bounded.

Practice nurses draw upon a multiplicity of discourses to explain the ways in which they work. Michel Foucault's (in Rabinow,1984:57-62) understanding of discursive power, power operating through discourse, is that it can be repressive or productive, or contain elements of both, in which case it can be contradictory. Practice nurses may draw upon their *specialised art of caring*[2] to confirm the

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[2] This phrase was used by Doreen Hounsell, 1994 Chairperson of the National Division of Practice Nurses, New Zealand Nurses' Organisation, in an address she gave at the national conference at Auckland in April

informal and gendered discourse that nurses are caring people, trained to listen and be confided in. They may draw on other discourses to resist the way obligations to be consistently "caring" constrain their opportunities to extend the scope of their work. Nurses' work is shaped by the expectations and assumptions of other people. In the case of practice nursing this involves accommodating general practitioner/s, clerical workers, perhaps a practice manager, many different patients, the regional health authority, and the nursing cultures[3] of which they are a part.

3.2 Allocation of physical space within general practice

Nurses are not only located in complex social locations in relation to doctors, clients and other health professionals, but also negotiate problematic spatial locations. The responses to the questionnaire indicated that practice nurses were concerned about the lack of physical space in which to work. One of the nurses specified that in the general practice where she was employed:

> *Rooms are too small to allow for privacy for patients who wish to see me.*
> (Questionnaire response from nurse employed at an inner city practice).

The nurses are expected to spend time listening to people's concerns and advising them about intimate matters. Much of their work is informed by the discourse that nurses are "people who care". Their capacity to engage in this caring is however, inhibited by the lack of private space available in which to do this work.

1994.

[3] Barbara Melosh (1982:207) identifies tensions arising from the co-existence of two cultures within American nursing: one culture of apprenticeship and one of professional ideology. Nurses who identify with the culture of apprenticeship tend to emphasize the "craft" skills of nursing, take pride in manual skills and often mistrust "theory", in contrast to nurses who claim increasing "professional" knowledge through collegiate education. The nurses who participated in this study valued aspects of both these "cultures".

Twenty-two percent of the practice nurses who replied to the questionnaire indicated that they had no space of their own from which to work. Fifty-one percent said they had their own space, but one nurse qualified this by adding that she shared this space with 8 other nurses, so perhaps the question was ambiguous and invited responses which indicated the nurses did not understand their "own" space to mean their individual space, and had instead understood the question to mean a collective space, for all the nurses in that practice. Twenty-seven percent indicated they shared an area designated for nurses. Twenty-nine percent gave "lack of space from which to work" as a factor which prevented them from extending the scope of practice of their practice.

In comparison to the general practitioner/s, most of the practice nurses I visited worked in smaller, less private areas of the building. The nurses rarely had one room each, while the doctors were often allocated two rooms. Most practices nurses shared a general space, usually known as the "nurses' room". Material from the interviews with other practice nurses confirmed that this is the most usual arrangement. In response to a question about what she disliked about her work another nurse wrote that there was:

> *...no room to call one's own. Have crowded nurses' station.*
> (Questionnaire response from nurse employed in a suburban practice).

In some practices, the nurses' room also served as the "treatment room", where nursing procedures were carried out. One could interpret this allocation of space as a reflection of both the lower status of nurses in the medical division of labour, and the relationship of employer and employee - an arrangement reinforced through the provision of the state subsidy paid to the general practitioner for the specific purpose of employing a practice nurse. Nevertheless, the extent to which this works in individual general practices is dependent on a number of related issues as well as allocation of space.

In older bungalows which have been renovated and converted into a general

practice, which was the case in three of the practices I visited, the general practitioner/s tended to move between the two rooms at the "front" of the house, formerly the sitting room and master bedroom, the largest rooms of the house. Most of the doctors preferred to work between two consulting rooms as this enabled the most efficient use of their chargeable time. If the practice nurse has "a room of her own" this is most likely to be at the rear of the building, in a former service area, like a kitchen or a laundry, and seldom completely private. This nurse explains such an arrangement, illustrating the tensions between her usefulness as a female smear taker and the minimal space allocated to her in which to undertake this work:

> *I have a room now that I call mine, it's the old wash-house, we did it up, (Doctor) recognised when I was doing the smear taking we needed somewhere extra, it's a nice comfortable little room now, quite small but cosy, as private as you can make it with staff toilet next door and staff kitchen through another door but I make a point of shutting the doors.*
> (Interview with nurse employed full time at a suburban practice).

The nurses explain their need for space in terms of requiring privacy, not only to perform procedures like taking cervical smears, but as a desire for working in ways similar to the "confidential" ways in which doctors work. If the popular discourse of nurses as women available to be confided in, to listen, to reassure and support, is to be reinforced, the nurses consider that they need a space in which they can guarantee people privacy.

I attended a practice meeting at an inner city practice where the practice nurses raised the possibility of their using a doctor's consulting room as a venue in which to take cervical smears. Their "nurses' room" had a couch squeezed into an alcove which made it almost impossible to negotiate certain procedures. The two doors, through which entrance was gained, were open constantly as the room was used as an alternate corridor. Even if it were possible, privacy was not guaranteed. The doctors were reluctant to concede any space and the request was turned down. One of the doctors present was a woman who could provide

female smear taking as well as providing complementary services, such as prescriptions for contraceptives. Fees for her services as smeartaker and prescriber were higher than those for the services of nurses. This illustrates the ways in which the business interests of practices can impact on the resources available to practice nurses, and the constraints they may experience in this environment.

At the conclusion of this meeting the two doctors left their tea cups in the nurses' room. The nurses told me sternly to leave them - when the doctors wanted another drink they would have to find and wash their own cups. The only direct reference the nurses made to their failure to access the space was to say that they felt *they are under utilised.* In this context the refusal to wash the tea cups seemed an attempt to somehow "manage" the doctors and resist status differences between nurses and doctors. To interpret this comment in this way would be to ignore the symbolism associated with such traditional tasks (McDowell and Pringle,1992:176), formerly accepted by nurses as part of their work, and now openly refused in most of the practices I visited. Washing the tea cups had seemed an obvious way to "earn" my time as participant observer in the general practices I visited. Another nurse, employed in a suburban practice, stopped me on one occasion from washing the dishes and told me very explicitly that *we are not into co-dependency here.* Many practice nurses want nursing to be seen as a profession separate from, but complementary to, the profession of medicine. Washing the doctor's cups is symbolic of the position of handmaiden from which many nurses feel they have emerged - inconsistent with the professional status they wish to attain.

The assumptions that practice nurses are available to meet peoples' needs is also inconsistent with nurses' professional interests in providing their patients with the privacy which general practitioners can provide. Even when engaged with a patient in a space that they can call "theirs", they can be interrupted by the general practitioner. As employers, doctors have authority to have their needs met first, as this nurse explains:

The doctors could open the door at any time as they see us as available to them.
(Practice nurse employed at an inner city practice; during informal participation).

Some nurses are able to access spare consulting rooms, especially in rural practices when rooms kept for visiting health professionals become available on a regular basis. Rural practice nurses appear to have a wider scope of work as they report being expected to make decisions of a medical nature when the doctor is unavailable. This gives some nurses a sense of autonomous practice as this nurse indicates:

Mainly our job is at the surgery but if the ambulance can't get there, or GP, then I have attended by myself....

You have said they are not there quite a few times - are you there all the time?

Lunchtimes they aren't there, you may not be covered for an hour and a half - they are always available by phone and there's always an ambulance, but...

I suppose in a rural area they may be visiting someone half an hour or so away?

Not often, mainly at lunchtimes...but sometimes someone will ring and he will say "you go, and ring me when you get there" and I'll go and consult by phone.

It strikes me that you are far too important a resource for the doctor to lose as he can't always be there and you can cover for that, and in a sense your availability makes his practice what it is...?

It does - it brings in clientele - as well as often they'll come in to see the nurse and they end up getting referred on anyway...typical thing is a Well Woman Clinic - as often they will come in with a nagging problem that they will tell you at the end when they've been with you for half an hour and they'll end up having to see the GP about it.
(Interview with nurse employed at a rural practice).

Both clients and the general practitioner for whom this nurse works expect that

she will be available, and she recognises the economic advantages to the practice of this availability. While the general practitioner may benefit from the use of her skills in this way, she can extend the scope of her practice in contrast to most nurses who work in suburban and inner city practices. In urban group practices there tend to be several doctors available so there is little opportunity for practice nurses to take on work usually done by doctors. In contrast in rural practices, practice nurses sometimes double as the district nurse[4] and the health promotion nurse and work outside the physical location of the practice. This may account for rural nurses indicating they work closely with other nurses (77%) compared to (27%) in inner city practices. At a meeting of nurses who work for doctors in the Pegasus Medical Group the concept of "a generic nurse" was mooted as a way of acknowledging the range of work done by rural practice nurses (Meeting notes,16.8.94). A pilot scheme using such the concept of "a generic nurse" has been set up at an urban practice, but practice nurses at this meeting expressed concern that this would contribute to the loss of identity of specialist nurses, and have what they described as ***a divisive effect.***

While space to work is a problem for many practice nurses, some nurses do have "rooms of their own". I visited a large suburban practice which employed 6 full time practice nurses, each working in their own rooms with appointment lists and computer terminals on their desks. These nurses were able to pursue interest areas such as managing chronic asthma, and one nurse helped a doctor with his interest in an overseas network of reliable doctors to recommend to prospective travellers, a type of privatised medical insurance. Another nurse employed at

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[4] Practice nurses in rural Canterbury have been providing district nursing services since the beginnings of the practice nurse salary subsidy scheme in 1970 (Clausen,1994:29). Nurse Maude District Nursing Association, which provides district nursing services in Christchurch, does not extend beyond urban areas. When the practice nurse salary subsidy was reduced from 100% to effectively 63% (Holland, Appendix E) in 1986, rural general practitioners refused to fund the difference for district nursing services, and it was provided by the former North Canterbury Hospital Board, now Healthlink South (Clausen,1994), who continue to pay general practitioners for this service.

this practice spent a lot of her time on the phone advising mothers with new babies. The doctor she works for is a young woman who is interested in delivering babies and developing a family oriented practice, so the business interests of her employer have had an impact on the ways in which this nurse works. Her work encourages parents with young children to consult her employer.

In some of the practices I visited the practice nurses had desks in the reception area. Most practice nurses are expected to work closely with the clerical workers to ensure the smooth running of the practice, to answer the phones when the clerical staff or receptionists are at lunch, or be the person to whom the receptionist can go to find out the doctor's movements, or give results to a worried patient. Some nurses are expected to perform reception and clerical work at various stages of their day, but **32%** of the nurses who replied to the questionnaire thought this aspect of their work was the **least** important part of their job. There were many comments on the tensions produced by requirements to do clerical work as this nurse explains:

> *(I dislike being) receptionist for an hour in the morning - rest of the time we are meant to answer the phone and process patients comings and goings on the computer - this is often difficult and demanding - as well as carry on "nursing" duties.*
> (Questionnaire response from practice nurse employed at a rural practice).

Most of the nurses I spoke with found the pressure on them to do the work of receptionists and clerical staff detracted from their positioning as "health professionals". There have been suggestions that general practitioners abuse the salary subsidy by utilising practice nurses as receptionists and even cleaners (Manchester,1995:13; Hounsell,1992:40). Barbara Docherty, a practice nurse who contributed to a fortnightly column in the *New Zealand Doctor*, asks ***why do so many practice nurses happily perform reception and other non nursing duties?*** (1994:28). The answers to this question lie in the crucial role practice nurses play in the organisation of general practice, in their lower status in the medical

division of labour and the socio-spatial features of the practices in which they work. If the nurse's space is in the reception area, it is more likely that nurses will be drawn into the work of receptionists. Ideas about practice nurses as those available to meet other people's needs also tend to facilitate their use in "people-focused" reception work. This tends to reinforce assumptions that nurses provide the "caring face" of medicine in contrast to the "curing" orientation of medical doctors.

One practice nurse I visited in a rural practice suggested that in contrast to nurses *the doctors operate behind closed doors.* The spatial arrangements of general practice maintains doctors' superior status as elite health professionals through social and physical distance. While within the medical profession general practice has had to struggle for recognition as a specialty, general practitioners maintain divisions between themselves and practice nurses through the symbolic use of space.

Nurses also occupy a significant position as the "human" front for the professionals for whom they work. Their spatial location in the practice is an important part of their positioning as professionals who mediate between clients and doctors. This can amount to a public relations exercise, making the patient feel welcome, and enquiring about other family members. An example of this at work was the nurse I visited in a suburban practice who lived locally and had been practice nursing for fourteen years. She greeted most of the people that came through the practice by name, and people stopped to talk to her about themselves and their families.

A practice nurse from a rural practice described herself as needing to be *in the middle* between the general practitioners and the other staff in the practice because she felt it was her responsibility to communicate to the staff that *things are moving on* in the sense of the practice initiating innovative health care and being up-to-date with treatment. The geographical community that the practice services has formed a committee which raises funds to equip the medical centre

where she works. In return, the practice nurse feels an obligation to provide information to the community and to be accessible in a visible form outside the space of the general practice, using means such as display boards with various topical health themes in the public Library and the local community Service Centre. This obligation to represent the general practice in the community is further complicated by her relationship of marriage to the general practitioner. She works very hard to communicate the ideal of illness prevention, helps run self-help support groups and even exhorts the supermarket manager to stock "healthy" food products.

3.3 "Consciousness of competence"

The orientation of nurses to coping with a variety of situations and exhibiting competence in a multiplicity of tasks is connected to the way practice nurses responded to questions which focused on the importance they attached to different tasks. In response to the survey question which asked them to identify important aspects of their work, most of the practice nurses thought **all** the tasks listed were either very important, or moderately important. Helen Cook (1986) describes what she calls the "consciousness of competence" which characterised women in New Zealand in the 1950s as they learnt to manage and juxtapose the work of home and community service. The "consciousness of competence" is also a crucial component of the culture of nursing, reinforced by historical accounts of nurses such as Florence Nightingale and Grace O'Neill who "managed" seemingly against great odds.

When I trained in the 1960s, to earn the respect of other nurses as a "good" nurse in a hospital situation, one was expected to cope with a wide variety of situations. A training nurse had to manage the physical and emotional care of several very ill people and work as a member of a hierarchal team which included the ward sisters and several doctors, all of whom may give you contradictory instructions. You had to be willing to empty messy bedpans and care for tiny children in pain, carry out the healthy baby for the new mother on discharge, but also ready to perform cardiac massage if you discovered a patient

in cardiac arrest. Nurses in training were expected to monitor symptoms such as blood in urine, sudden increases in blood pressure or the onset of a diabetic coma.

Although practice nurses work under different conditions, the "consciousness of competence" is enhanced by the life experiences of many of the nurses which have similarly demanded the capacity to do several things simultaneously and demonstrate competence across a broad spectrum of tasks. Most of the nurses (86%) have worked in other nursing positions before working in general practice and had many other experiences such as caring for children in their own homes (66%), undertaking voluntary work for pre-schools and schools (70%). Many of them have had education in other fields (36%) as well as post graduate education in nursing (70%).

One of the practices I visited only employed nurses who had had experience in caring for their own children. Most women in New Zealand society still have the primary responsibility to care for small children and their experience as parents is often valued and sought after by general practitioners. In this respect, general practitioners draw upon specific gendered attributes and skills, learnt through involvement in what is referred to as "the private sphere". These informally acquired skills provide a vital link between the private world of parents and the privatised public world of general practice. At one level, the requirement that practice nurses are, or have been, mothers is a discriminatory practice. At another level, it demonstrates the artificiality of the divisions between "public" and "private" spheres, and formally and informally acquired skills. Working with a "consciousness of competence", being constantly alert, can mean that nurses assume they are responsible for meeting **all** needs - and find that they have difficulty distinguishing between nursing and non nursing tasks. One nurse indicated:

> *Many practice nurses who said they were busy were doing trivial things they saw as needing to be done, but not necessarily by a nurse.* (Practice nurse employed in a suburban practice; during informal participation).

On the other hand, practice nurses are sometimes chosen as professionals with certain life experiences because their employers want to access their formal and informally acquired commitment to competence across a range of very diverse tasks. Doctors may want nurses who will do what they see as "needing to be done".

KNOWING THEIR PLACE: AREAS/SPACES OF WORK ENGAGED IN BY PRACTICE NURSES WITHIN GENERAL PRACTICE

Practice nurses talk about working within what I have defined for this discussion as three main related spaces/areas. The first area they call nursing tasks, the second is in the area of health education and illness prevention; and the third is the area which cuts across both these areas - the role of nurses as advocates for their patients.

3.4 Nursing tasks

Many of the nurses talked about their performance of nursing tasks as their main contribution to the nursing service provided by general practice. By "nursing tasks" they mean clinical work - for example dressing difficult leg ulcers, immunisation, syringing ears, taking blood pressures or cervical smears. They find this practical aspect of their work satisfying. As they tend to be the person who interacts with the sales representatives of companies specialising in medical supplies, they can readily update their knowledge of new products. Their claim to expert knowledge in this area can have a positive impact on their relationships with general practitioners, who sometimes regard nurses' treatment of patients as a challenge to their jurisdictional (Abbott,1981,1988)[5] claims. This is particularly so in the case of wound healing, an area which a significant number of practice nurses identified as their area of specialty.

One nurse described to me how she confronted a general practitioner over a

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[5] Andrew Abbott (1981:190) uses the concept of "jurisdiction" to describe the link between a profession and its work. It refers to claims of professional expertise necessary for particular works.

wound for which he had prescribed a dressing method she considered was out-dated. She asked him how much training he had had in dressing wounds, and when he confessed to no formal training, she asked if he would agree to her using a dressing which she felt was more appropriate. He agreed, and was surprised at the result. She felt he was threatened by her knowledge, but because she had approached him:

> *...in a sensitive manner and not in front of the patient, he had been willing to learn.*
> (Interview with practice nurse employed at a suburban practice).

Another practice nurse described how she had to be very careful about the way she provided advice to doctors about appropriate treatment of patients:

> *He walked into the office a couple of weeks ago and said "Mrs So-and-so isn't really getting any better, what are we going to do about it? What do you think about antibiotics?" and I said "The latest thinking is long term antibiotics are more effective for this sort of thing than short term, what say we try <u>this</u> as a dressing and you give her a course of <u>that</u> and maybe two weeks down the track we see if we're getting somewhere". He's becoming more and more amenable to that sort of thing now as long as he thinks it's his idea in the first place...I've been dropping all sorts of suggestions for ages, it's all subtlety ...I keep up with what's happening where he doesn't and he's obviously starting to recognise that...*
>
> **It's interesting...the sort of strategies you have to use...**
>
> *Yes, to get the best for your patients and I believe it's all part of our perceiving and we do it all the time.*
> (Interview with practice nurse employed at a suburban practice).

Using these strategies practice nurses seem to be able to question forms of treatment, and suggest alternatives. In this respect the dynamics of general practice exemplifies the "doctor-nurse game" identified by Stein, Watts and Howell (1990). They argue that this "game" involves nurses communicating their recommendations without appearing to claim authority as professions as they relate to another professional group which has historically occupied a superior position in health care.

Nurses often feel more comfortable about giving contrary advice to doctors when

the doctors are relatively young and inexperienced. One of the rural practice nurses I worked with asked an elderly woman what dietary advice the young doctor had given her in view of her high cholesterol result. She was dressing the woman's leg ulcer at the time and enquiring about other aspects of her health. When the nurse heard the young doctor's suggestion of wholemeal lettuce sandwiches for breakfast she roundly criticised the idea, sending the elderly woman away much happier. This illustrates the way age and experience interacts with the traditional doctor/nurse hierarchy to construct practice nurses as more or less assertive relative to doctors.

The notion that nurses are more accessible to patients than doctors means the practice nurses are expected to take telephone calls as part of their duties. Answering the telephone was mentioned frequently in reply to the open ended question as to what the nurses disliked about their work, and typifies the tension nurses feel over the varied expectations they feel obliged to fulfil:

> *(I dislike) the phone - bombarded with absolute dipsticks, in inner city we get a lot of "subbies" - the real low life types which can be very demanding and difficult to handle.*
> (Questionnaire response from practice nurse employed in an inner city practice).

This nurse constructs herself as morally different to people she categorises as *real low life*, but as an inner city practice nurse her professional work demands interaction with those with different life styles. This particular practice was composed of a wide range of clients including a high proportion of addictive drug users, people who depended on her to ensure that their methadone prescriptions were available from the doctor. Whereas the doctors may distance themselves from patients by using nurses and receptionists as a buffer, practice nurses have no such authority. They are constrained by the obligation to "care", even if some of them position themselves as significantly different from the people for whom they have been employed to "care".

Practice nurses tend to be less constrained than doctors in terms of chargeable time requirements. They are able to spend more time performing clinical tasks

and accessing appropriate agencies. At one level, their place in general practice is one of overall surveillance, a location relative to patients and doctors as this nurse succinctly articulates:

> *In dealing with the files I am able to get a holistic view of what's going on, and can alert the doctors to anything they've missed.*
> (Practice nurse employed at a suburban practice; during informal participation).

This nurse describes her work as *finishing off the health care.* She spends a lot of her time engaged in doing the liaison type duties at the end of the consultation - filing, phoning for results, making specialist appointments and times for laboratory tests. Her commitment to alert the doctor/s to anything they've missed, particularly results which necessitate action, indicates her adherence to a biomedical model of medicine, and a loyalty and close association with her employers. It is important to this nurse that doctors in the practice are aware of information about their patients/clients and act on it. At the same time, this particular nurse demonstrated a holistic approach in the sense of being personally interested in all aspects of the patients/clients who came past her desk, including their personal well-being and that of their families. The space she occupies seems closest to that of a mix of clinical and managerial functions, providing satisfaction and service to both patients/clients, and her employing general practitioners.

As employees, practice nurses are requested to engage in a wide variety of tasks, most of which they perform willingly and with considerable competence. Nevertheless, they "own" none of the outcomes - the overall success of wound healing, and other procedures the nurses perform, such as immunisation, are submerged into the overall rates for the practice as a whole, and credited to general practitioners.

3.5 Health education and illness prevention

Some practice nurses feel their positioning is primarily as educators in the field of health promotion and illness prevention. This includes child health checks,

health assessments and education about preventing illness. Recent research on this area of general practice in the United Kingdom indicates that general practitioners found the actual practice of prevention problematic, and tended to delegate this work to their practice nurses (Williams and Calnan,1994:372). The doctors were reported to find health promotion work dull and repetitive, and a constraint on their time. They expressed concerns about the uncertainties of risk factor identification, the effectiveness of behavioral change, and issues associated with the legitimacy of moral intrusion into the lives of others, and inflation of people's anxiety levels (Williams and Calnan,1994:372).

Andrew Abbott argues that creating and maintaining nursing as a subordinate group allows the medical profession "to delegate the dangerously routine work" (1988:72). This can enable practice nurses to occupy this niche and adapt as this nurse indicates:

> *Since the philosophy of the practice was to provide preventative health, I came on board with a very nebulous job description...as a non-clinical nurse...looking at health promotion and education...I have to be always proactive and I cannot just sit back and wait for it all to happen. A good day is when I have a whole day of appointments. I set my own goals at the beginning of the year...A lot of my work could be seen in the new framework, if you're looking at budgeting, as case manager. Because of this position I have the flexibility, not only to go into the homes and do assessments but I have the autonomy to pick up the phone and access agencies as I see fit...naturally I always feed that directive back into the practice, or work to the doctor's directive.*
> (Interview with practice nurse employed in an inner city practice).

This nurse is speaking the language of the current health reforms. She is very aware of budgeting and the need to be accountable for her time. She is also committed to being proactive. She has a fixed title and specific goals. As employees who are usually expected to engage in a wide variety of tasks, few practice nurses are able to occupy such a specific niche, but try and fit health promotion into other interactions with patients. I noticed that some of the patients tended to treat the nurses' well meaning remarks as a bit of a joke - a very stout young man was asked by one nurse if the doctor had spoken to him

about his weight and he said: "No, but that other nurse - she was on to me about it" (Informal participation in inner city practice).

It is perhaps easier for nurses to offer patients such unwelcome advice as their income is not dependent on patients returning to the practice. Doctors do feel uncomfortable with the moral dimensions of such advice (Williams and Calnan,1994), and are happy for the nurses to offer it, especially since nurses have been identified as being more effective than doctors at health promotion strategies like persuading people to give up smoking, loosing weight, and controlling blood pressure (Warden,1988; Greenfield,Stilwell and Drury,1987).

This aspect of the nurses' work ties in with the explicit goals of the state subsidy. Moreover, this sort of activity brings business to the general practice. The allocation of the subsidy provides a tool by which the state can allocate to certain women with professional status the task of policing the health of the population through formal strategies such as immunisation, and informally through deployment of their "caring" strategies which appear to include advice which promotes good health. At the same time, the provision of a subsidy maintains the superiority of medicine in the division of health care labour by providing general practitioners with nurses who are their employees and whose range of professional practice is controlled by another professional group.

The practice nurses consider their work on immunisation very important and call upon understandings which are gendered as they articulate the importance of their "place" as nurses in general practice. At the National Practice Nurse Conference, New Zealand Nurses' Organisation, in Auckland in April 1994, a panel discussion highlighted the nurses' understanding that both the service and the rates of immunisation were their responsibility. The aim expressed at the conference was to have a 90% rate of immunisation by the year 2000. This was to be achieved by strategies described by a practice nurse who came to the microphone wearing a hard hat, such as those worn on a construction site, and a carpenter's apron from which she pulled large signs - the "tools" nurses would

need to reach this goal. They included a recall system, an age-sex register, education, the use of the media, networking with other nurses working in the community, being accessible (including doing their shopping at lunchtimes in the hope of prompting recalcitrant parents in the supermarket to vaccinate their children), and paying attention to themselves - their commitment level, the updating of their skills and their knowledge of immunisation programmes. She finished by noting that the best way to get people to use immunisation was for practice nurses to contact them personally: ***we are good at this, this is where our skills lie*** (Conference notes, April 1994).

Margaret Tennant (1991) has suggested that New Zealand nurses have functioned as "missionaries of health". Her focus was on the zealous attention to health by school nurses in the 1930s. Discourses of nurses as "family centred and people sensitive" continue to be drawn upon by practice nurses to explain aspects of their work and their particular position in the health care team. James and Saville-Smith (1994) argue that there is a gendered culture in New Zealand, derived from complex interaction between indigenous and colonial structures during the early period of colonization. To resolve problems of maintaining the provision of some forms of welfare and controlling men and children while maintaining men's authority, the state emphasised the social role of women as wives and mothers through a particular construction of femininity (James and Saville-Smith,1994). Women, constructed by themselves and the state as the moral guardians of the community, were often the instruments through which the state imposed domestic order on men, children, and sometimes other women.

The moral superiority of women and their usefulness in restoring order and stability were as important as medical knowledge in the initial provision of the practice nurse subsidy scheme. Although space for nurses within general practice was created in response to a particular need for medical care in rural areas, the architects of the subsidy scheme sought to provide the general practitioner with "an assistant to relieve him of tasks appropriate to a nurse, so allowing him more

time for tasks more appropriate to his skills and training" (McLennan,1984:34). The creation of practice nursing as an occupational specialty was therefore closely tied to the construction of general practice as a medical specialty which consolidated doctors involved in primary health care as involved in more specialised work than nurses.

One way in which nurses relieve doctors of tasks which would otherwise be their responsibility is through routine "screening" of patients. By "screening", practice nurses perform both preventative components of primary health care and meet the requirements of general practice as a business. "Screening" refers to the detection of conditions which can be treated before becoming chronic, requiring long term, expensive medical care. Some nurses are required to screen people before they see the doctor, most commonly taking patient/clients' blood pressures. Some nurses see this as valuable in the sense that they can save the doctor time rather than a service to the state and a requirement of the subsidy:

> *Whenever possible I or the receptionist would put a patient in a room, my doctor had two rooms, and every possible chance I had I would go in first and see if the patient was coming for a condition related to blood pressure, or diabetes, or maternity patients I always checked up on first whatever...one of the doctors in my practice actually required his nurse to enquire what the visit was about...I could often save the doctor quite a lot of time...you know people would come in for a pregnancy test and think they had to see the doctor first..*
> (Interview with practice nurse employed at suburban practice).

The practice nurse quoted above explained she was extremely busy - *95% of the time just about run off my feet.* At this point in the interview she was describing the need for her to be as "efficient" as possible. By being seen by the patients as "efficient" she may be comforting anxious patients. These are tasks seen by nurses as important nursing tasks, complementary to medicine. Notions of time and space, gender and economics are woven together to inform the way practice nurses work as this practice nurse indicates:

> *The practice nurse is often both known and unknown to patients...she is often distant enough from the family to be taken into confidence.*

> *Patients usually feel the pressure of time less when they are consulting with the practice nurse. They know a queue of patients is not sitting outside the door and they also know sessions with the nurse are either free or considerably less expensive than those with the GP.*
> (Lynch,1989:24).

David Armstrong has written of the "fabrication" of nurse-patient relationships. He describes the processes whereby nurses construct a new identity for people - as patients (1983:459). The positioning of the practice nurses as advocates, as confidantes and as detectors of "abnormal" conditions tends to reinforce the identity of those in the surgery as "patients" - potentially in need of services which will generate income for the practice. Practice nurses are advocates in the sense of being in a position to speak for certain patients within the context of general practice, but they are also at times those who identify which patients are potential candidates for "treatment" by doctors.

In this sense, practice nurses are often advocates of medical intervention, operating within the biomedical model of health care delivery. When practice nurses are administering immunisations they may also offer parents the opportunity of child health and development checks. These checks begin a process of surveillance which can be continued throughout a life span. The promotion of "healthy guidelines" endorsed by state actors can be also seen as ways of policing and regulating children. In this case the practice nurse serves as effective agent of the state. Health policies concerned with immunisation legitimate the authority of medicine as an institution.

The wider issue of who the practice nurses and general practitioners are reaching to immunise is beyond the scope of this study. However, the nurses who participated in my study were exclusively Pakeha women. None of the committee members of the Canterbury Practice Nurse Division knew of any Maori or Polynesian practice nurses working in Canterbury at the time of my study. This raises questions about the appropriateness of the place of general practice as the primary provider of health care services for all New Zealanders

(Southern Regional Health Authority,1994:6). It is somewhat of a paradox that the "front" presented by most general practitioners in the shape of the practice nurse may be seen as a reflection of the dominant culture and may work in some ways to maintain the present inequalities in health care delivery that the Southern Regional Health Authority hopes to correct (1994:6).

3.6 Practice nurses as advocates

Many practice nurses are explicit about their role as "patient" advocate. This nurse describes her positioning as patient advocate as something which transcends the economic interests of the practice or individual doctors:

> *Really the nurses are still the patient advocate, aren't they?*
>
> **Is that how you think of yourself?**
>
> *Yes, still very much so...the patient comes before the doctor and the money he makes.*
> (Practice nurse employed full time in a rural practice).

This nurse indicates her sense of the way practice nurses are positioned as public employees paid for by the state, despite their status as the private employees of general practitioners working in small businesses. Sometimes nurses operate as intermediaries between patients and what this nurse calls "the system":

> *We've got a lot of very young parents with young children, sick children, it's really quite awful at times - we have one family that we can see - in a fortnight we can see them every other day, then we'll have a fortnight without seeing them, but they'll be on the phone to me every day - their parenting skills are zilch, their children are unwell, but not that bad, but they just don't have the skills to cope with it and no matter how hard we try to get them some parenting skills it isn't out there unless you can pay for it - so you try hard with your reassurance and support "you're doing the right thing, keep at it etc etc". It's very frustrating, I get very very cross with the bureaucrats and what have you because it seems that there's nothing there, there is no way you can get into the system. I have a notebook on my desk with all the helpful numbers in it...a large part of my day is trying to get help for people, trying to get into a system for someone who is in distress.*
> (Interview with practice nurse working full time in a suburban practice).

Nurses' advocacy may also involve elements of power "over", as well as power to effect outcomes "for", patient/clients. It seems as if social spaces which facilitate practice nurses acting as "patient advocates" are also associated with their construction of nurses as those who undertake, as part of their professional work, the role of moral guardians of the community, often attributed to women in general. This practice nurse's comments of the "need for parenting skills" indicates that nurses are positioned as both those who evaluate the parenting skills of others **and** as professional health care workers.

3.7 Practice nurses within the nursing profession

Practice nurses are the single largest group of nurses working in primary health care in New Zealand. They have just celebrated twenty five years of practice, and form a group from which a new culture of practice nursing is beginning to emerge, one which adds to and reworks earlier ideas about nursing. Practice nurses tend to compare their work favourably with hospital nursing in terms of their relative freedom from hierarchal decision making, but they still acknowledge the influence of their hospital training. As this nurse says:

> *It's nice to be able to relax a little and give support to the community compared to high stress hospital nursing with little thanks and being so institutionalised and please the hierarchy - but I have gained invaluable experience in the hospital that I can now use in the practice.*
> (Questionnaire response from practice nurse employed in a suburban practice).

Practice nurses see themselves as better able to act as autonomous professionals than hospital based nurses. This autonomy is most evident in rural practices where nurses are required to make instant medical decisions when doctors are absent. There is potential in practice nursing for greater flexibility to pursue alternative areas of work like domiciliary work in combination with the requirements of the practice - flexibility which tends to be denied hospital nurses. The spatial location of general practice in the "community", and its construction as the ideal nexus from which to deliver primary health care, is crucial to this potential in the current context of emphasis on low-cost prevention

of illness. The positioning of practice nurses in general practices which are small businesses allows them to make judgements about who has to pay what for services, and to actively market their individual services in the community.

At the same time, practice nurses currently earn less than district nurses and public health nurses (Beckingsale,1995:37). I interviewed a practice nurse who was a trained Plunket nurse[2]. In recognition of her Plunket training her employing general practitioner paid her a little extra, but as she explains:

> *When I came here I actually took a decrease in my wages because Plunket nurses are paid quite a bit more than practice nurses.*
> (Interview with nurse employed in a suburban practice).

Some practice nurses indicated that they felt that they were "looked down upon" by hospital nurses, that nurses who worked in hospitals tended to see practice nurses as receptionists rather than nurses. Practice nurses felt this view neglected the range of professional skills required of nurses in general practices.

Within general practices, allocation of physical space tends to also impact on the relationships of nurses working at the same practice. The tendency for practice nurses to be mature women with childrearing skills may set them apart from younger Polytechnic trained nurses who may not see those skills as part of "professional" work. One nurse spoke about the *"bitching"* that she said went on at the practice nurses' meetings. She saw this as mostly due to her positioning as a younger Polytechnic trained nurse keen to implement the new techniques she had been taught. Elements of divisiveness due to different training were sometimes cited by practice nurses during the fieldwork. One nurse, who was

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[2] Plunket nurses working with Plunket Line are paid an hourly base rate of $18.08 for working on Monday to Friday between the hours of 7 am to 7 pm (This information was collected in a telephone conversation with Kay Galloway, New Zealand Nurses' Organisation, Wellington). This is contrast to the hourly rate of $15.82 for practice nurses party to the National Collective (announced by Kay Squires, Organiser, New Zealand Nurses' organisation, 26th June 1995 at a practice nurses' educational evening).

moving positions, said:

> *The new nurse will have to get on with the other nurse as the room is too small for them not to get on.*
> (Interview with practice nurse employed at an inner city practice).

3.8 Some conclusions about spaces for practice nursing

Feminist geographers Geraldine Pratt and Susan Hansen (1994) argue that social relations are constructed, and reconstituted through location in certain spaces. The social relations between nurses and doctors, between nurses, and between nurses and their patients/clients are significantly shaped by the distribution of physical space between health professionals in general practices. They are also shaped by time, gender and the economics of general practice. Practice nurses are located in a range of positions which are often contradictory. In relation to the general practitioner she can be identified as a supervisor, an assistant, a business associate. In relation to the patient she can be seen as a mother, a confidante, an advocate, an agent of the state. In relation to the nursing profession she can be seen as a glorified receptionist or an innovative nurse practitioner.

For Andrew Abbott (1988), "doing professionalism" involves setting up interdependent systems of training and surveillance of members boundaries and networks. Some professions successfully claim full jurisdiction, backed by legal and organisational rules, while others like nursing, have had to accept "limited" settlement. This limited autonomy of nurses in relation to medical doctors has to be constantly maintained and, as Abbott argues, this "requires countless acts of exclusion...and coercion" (Abbott,1988:73). He writes that the

> turn-of-the-century general practitioners in England feared with good reason that on-the-job nurses were successfully invading the primary care market that was their bread and butter (Abbott,1988:72).

Nursing is a profession which is both subject to the controls of medicine, and is

an autonomous field of work with its own hierarchies and areas of specialisation. This study of practice nursing indicates the ways in which nurses both experience constraint and control in relation to doctors, and also the ways in which they resist that control. Practice nurses locate themselves at one level as state paid, autonomous professionals and at another level, as employees in small businesses owned by other professionals, who define the details of their professional practice. It seems that opportunities for some practice nurses to engage in more innovative ways of working are linked with the business interests of general practice. This is the focus of the next chapter.

CHAPTER FOUR

THE BUSINESS OF CARING

"Primary care - just a business with a heart"
(Simon,1994:35).

In New Zealand, primary health care services are delivered principally through the small businesses of general practice. The individual businesses of general practice function within statutory and regulatory controls developed by the Ministry of Health and the Medical Council. These construct general practice as a limited form of monopoly, complete with gatekeeping privileges to specialised health care services. General practitioners have had the right to charge a fee-for-service from their patients/clients, "commensurate with the service given" (Cole,1995:8) together with an assurance of some payment from the state, since 1941 (Richards,1981:63). General practice as a business is significantly supported by the regional health authorities through the provision of subsidies, funded by the taxpayer, including the General Medical Services subsidy which reimburses general practitioners for patient consultations, and the practice nurse salary subsidy[1].

In the rhetoric surrounding health care, the business of general practice is generally presented as secondary to professional commitment to the health and well-being of patients. In practice, financial success of general practice as a business is crucial to the availability of this "public" service. General practice is also about "care", particularly community based primary health care. As the employees of general practitioners, practice nurses are implicated in this tension between professional "care" and the commercial interests of the practice as a

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[1] Other subsidies include the pharmaceutical subsidy, and the community laboratory and radiology subsidies. In most cases the services covered by these subsidies are subsidised on a fee-for-services basis which means the regional health authorities pay a subsidy for all appropriate services received from, and claimed by, general practitioners.

small business. While the state subsidises most of their salaries, they work in small businesses as professionals whose work is shaped by commercial interests as well as patient need.

This chapter focuses on business components of the forms of professional care provided by practice nurses. It examines three themes which were identified through analysis of questionnaire responses, field work observation, and interviews. The practice nurses in this study tend to identify with the altruistic values associated with the culture of nursing. Nurses generally value professional "care" and patient need over commercial transactions and ability to pay. Working in general practice, balancing notions of "care" with what it will cost, the nurses are however required to, and do, make commercial decisions. A rhetoric of business then becomes crucial to the provision of care, a situation which contributes to contradictory and ambiguous feelings expressed by some of the nurses. Secondly, through their commitment to the rhetoric of preventive health, the nurses maintain an apparatus of surveillance, one which both evinces and helps maintain people as patients/clients over time, and exemplifies professional health care as a form of social control. Finally, the "service" nature of work required by individual businesses of general practice often poses challenges for practice nurses who are required to mediate between patients/clients and other health professionals, but also construct their own professional identities. These themes are woven together through the rhetoric of teamwork, played out to differing extent in individual workplaces.

There has been an accumulation of rhetoric around the notion of care (James,1992) including the identification of caring as an integral part of doing "good business" (Hochschild,1983). Medical practitioners have always recognised a "duty of care" (Cole,1995:5) but in individual businesses the delivery of good "service" is an essential marketing strategy, as recognised by Professor Cole:

> Younger colleagues, both specialists and GPs now talk about the need to market medicine. Although this causes shudders through ageing medical spines, it is the reality of modern medicine (Cole,1995:85).

Aspects of the nurses' work, frequently gendered and often learned through unpaid experience in the domestic arena or community involvement, are used as a resource by businesses of general practice to maximise economic return while consolidating the nurses' positioning as helpful givers of health care. The contradictions of this coupling of "doing care" and "doing business" are encapsulated in the metaphor of *Primary care - just a business with a heart* (Simon,1994:35). A metaphor such as this constitutes people working within such a situation in multiple or contradictory positions (Davies and Harre,1991:53). Positioning is a different concept from role, where the person can always be separable from the role they are in. In positioning, the focus is on the way in which discursive practices constitute the speakers (Davies and Harre,1991:62). Although the practices where individual practice nurses work differ, with respect to location, size, and clientele, the stories told by different practice nurses illustrate the resilience of discursive practices associated with caring and the emphasis on health promotion. Practice nurses also speak of the difficulty they experience in asking people to pay for their services.

The publicly subsidised health promotion and illness prevention work of practice nurses connects individual businesses, specialising in primary health care, and the public health policies of the Ministry of Health. The siting of nurses in private general practices facilitates the implementation of primary care policies through an authoritative and disciplined workforce. Practice nurses use a combination of "family carework" (James,1992:491), and "scientific" knowledge and skill in activities such as immunisation. This combination of formal and informal skills is used to bridge the gap between the patient/client, the paid health professional in the public sphere, and the regional health authorities - the third player whose main interest is keeping particular populations disease free in cost efficient ways.

4.1 Practice Nurses' understanding of "care" as given in general practice

Many of the nurses in this study see women and nurses as "caring people" and the value they attach to their work has been reinforced through voluntary work

in the community and unpaid domestic labour. Helping people is intrinsically satisfying for many practice nurses as responses to the questionnaire illustrated:

> *Sounds corny but helping people - really satisfying when you make a change take place.*
>
> *When you achieve something with them (patients) or make them feel good - you feel good.*
>
> *(I feel) satisfaction at the end of the day that I have personally given as much as I can towards health maintenance and care of my patients.*
> (Responses to the questionnaire).

Practice nurses are paid to be caring. This is paid work which makes them feel good about themselves. They are also paid to help run a business, to render their care in a commercial enterprise. The challenges of balancing the commitment to care and the requirements of a commercial practice is illustrated by the following quote which comes from an interview with a rural practice nurse. It suggests some of the contradictory and complex feelings practice nurses articulated when they talked about the business of caring.

> **Are you aware that general practice is a business? Are you conscious of costs?**
>
> *No, we've got everything that there is to have...I've made sure we've got everything necessary...if they worry about costs then I transfer those charges over to patient charges. One of the GPs approached me the other day and said we were over ordering on our supplies and I said "I am not ordering any more - we are using good suturing material that both of you prefer, the cost has gone up" - and he said "the costs have gone up phenomenally, the accountant has pointed it out". I said "I bet you had forgotten we ordered the autoclave" and he said "oh yes, I'd forgotten about that" - and I said "if you want me to go back to the dark ages I'll start getting paraffin and just a bit of gauze but I'm not prepared to do that" - and he said "oh fine". They're really very good. I know in my heart that the care we give is very good.*
> (Interview with a nurse employed in a rural practice).

This anecdote illustrates the "infinitesimal mechanisms of power" (see Foucault,1982) which are played out at microlevel in general practice. Nurses

are employed by general practitioners, but make key commercial decisions with respect to medical supplies. Criticism of the cost of supplies by one of the doctors generates an assertion of professional responsibility for the welfare of patients. In this instance "care" may involve access to expensive modern equipment, but "good care" is used to refer to the total care available at a particular practice. Practice nurses are constructed as those who ensure care is "very good" regardless of commercial imperatives.

Some feminist writers have commented on the gendered distinction between caring "for" and caring "about" (Tronto,1989; Ungerson,1987). Women are assumed to care "for" people by doing the direct work of caring, especially for their families; men are assumed to care "about" money, ideas - they show they care by the work they do and the values they hold (Tronto,1989:172). The work of practice nurses cuts across this distinction as they both care "for", in terms of doing caring work, and also "about", in terms of their commitment to health promotion and illness prevention, operating recall systems, performing immunisations, referring to appropriate agencies for help and support.

Practice nurses care "for" two divergent strands of people. They care firstly "for" the patient whose ears they syringe, and whose worries they listen to; secondly, they care "for" the general practitioner, whose practice they ensure runs smoothly in terms of adequate medical supplies, and a flow of "screened" patients/clients, and for whom they often act as public relations specialist. Sometimes, practice nurses act as "gatekeepers for the gatekeepers" in the sense of deciding when it is appropriate for people to consult general practitioners, and when it is not, as this nurse indicates:

> *I knew pretty well what most people were coming for, and I could quite often save the doctor quite a lot of time...you know sometimes people would come in for something like a pregnancy test and think they had to see the doctor first...*
> (Interview with nurse who was employed at a suburban practice).

Most nurses support the general practitioner/s they work for in terms of tying

up loose ends, especially with respect to conveying information necessary for prescribed treatment to be put into practice. While I was observing in an inner city practice a patient rang to say the drug the doctor had prescribed had not been written on the prescription form. The practice nurse had to check with the doctor, ring the chemist to say this drug could be dispensed and delivered, write the prescription and get the doctor to sign it, then post the prescription off to the chemist. Then she phoned the patient to tell her that she had arranged for the medication to be delivered to her, and to apologise for the doctor's mistake. Her role was pivotal in a public relations exercise which involved placating the patient and the chemist. This is just one example of the time consuming organisational work most practice nurses do all the time.

4.2 The issue of gender

While many practice nurses sometimes feel uneasy about the commercial aspects of their work, they focus daily on a delicate combination of attention to care and cost. The association of "good nurses" with "good women" (Mackay,1992:34), is not difficult to make. Most nurses are conscious of cost and waste and, reminiscent of housekeeping practices, work hard to diminish both. In one inner city practice I helped the nurses cut disposable pads in half to lessen waste, a time consuming task they did on their own initiative. However, these sorts of practices are in tension with the professional attributes of skill and expertise in nursing with which nurses want to be associated. The same practice nurse always checked on the computer after the general practitioner had seen each patient to make sure the doctor had remembered to claim the General Medical Subsidy. She saw herself as crucially involved in tasks which would contribute to the income of the practice and cut costs:

> *I'm very aware that this is a business and we have to be careful of what we use and do.*
> (Nurse based at inner city practice, during informal participation).

Some analysts (Manley,1995; Witz,1994; James,1992; Boyer and Nelson,1992; Oakley,1986) have made strong arguments for gender as a crucial factor in

interpreting nurses' work. The approachability and availability of practice nurses, influenced by feelings of affinity, provide the context for an initial contact which might trigger a chain of events, such as described by the practice nurse in this interview:

> **Do you find people want to see you to talk?**
>
> *I personally find quite a few people do - they make an appointment for their child but it is really just support they are looking for, someone to talk to...you can tell so much by watching people - I mean what's going on in a family...the need for things.*
>
> **Can you refer people on?**
>
> *A certain amount...if it needs referring I would usually go through the doctor, when I'd seen them I would pop them round to the doctor's sideroom with a note or ring the doctor and say look I've got so-and-so, can you just check on something? I refer directly to Plunket's family centre, I use that a lot for support for people - most of the other things I usually go through the doctor for the OK for it.*
> (Interview with nurse based in a suburban practice nurse).

In the case of general practice, elements of work assumed to be gendered such as responsiveness, empathy, and reliability, together with experience gained in the private sphere of domestic households, are recognised as relevant to professional work. At another level, these elements are also critical dimensions used by customers of companies to judge the quality of service (Tjosovold,1993:4), and are equally relevant to the delivery of health care services in an individual business.

An inner city practice nurse told me that the young female general practitioner who employs her prefers nurses who have had their own children as her clientele mainly consists of women, and the nurse's experience is invaluable to her. This young woman doctor finds her services preferred by women because she is female, yet she finds that she needs to draw upon the childrearing experience of her practice nurse as well as her more formal nursing skills. At another level, other practice nurses working with female general practitioners found the likelihood of being paid to learn new techniques and performing tests like

cervical smears, were reduced as the female doctor performed such tests as part of the continuous comprehensive care given in their consultations. A poll undertaken for *New Zealand Doctor* in 1994 confirms that working with a female doctor does not make professional boundaries easier to cross:

> Professional pride seems to override female solidarity, with female doctors just as likely as their male counterparts to believe that extending the role of the nurse is not a good idea (Thompson,1994:4).

This contrasts with the experience of another suburban practice nurse. She worked for a male general practitioner and had gradually taken over doing cervical smears and breast checks as she found many women asked particularly for her services. The doctor, worried about the possibility of missing something he should initiate action on, had asked her to take the further responsibility of sorting out all the smear results so he only had to view the abnormal results. This nurse explained to me the male doctor used to boast he could do a smear in two minutes, but she took pride in the fact that, although she took longer, women tended to thank her for being so gentle. In the context of a working relationship with a male general practitioner, the gender of the nurse is an advantage in widening the scope of her work, and at the same time it enables the business to meet a demand for a service which potentially brings in new patients/clients. At another level this example illustrates the embeddedness of the organisational aspect of practice nursing - the crucial work of the nurse who checks the smear results.

4.3 Juggling competing demands: nurse as facilitator of the primary health care "team"

Like wives and mothers who take responsibility for maintaining and sustaining the domestic arena, balancing the various needs of the family, practice nurses juggle a variety of demands in general practice. One nurse was very specific about the organisational qualities practice nurses need, she called it a "housewife mentality":

> *I really think that to be a practice nurse one almost needs a housewife mentality and I've been a housewife for a large part of my adult years. When I say housewife, the aspect of the housewife mentality for me in practice nursing was that I had to move, very quickly, from one task to the other, with constant interruptions as one has with children...and that was the name of the game really, doing one thing and trying to keep one's mind always attuned to what the doctor was needing one to do so that patients would be ready...and yet not keeping other patients, who were just for the nurse, waiting too long...and in the middle of this always phone calls. There was a lot of phone work involved in hearing people's needs, and looking after prescription concerns.*
> (Interview with practice nurse employed in a suburban practice).

Replies to the questionnaire indicated some of the strains of meeting these contradictory requests, as indicated by this nurse:

> *It's tiring and sometimes very constant. In the ideal situation people would be in the right place at the right time - doing the right thing. Some days it's a breeze and it flows - others - it's at you from all directions and our systems break down - we have to keep putting systems in place - it keeps evolving because the practice is evolving and growing.*
> (Questionnaire response from nurse employed in suburban practice).

General practice is a service occupation producing health care services. Co-operative efforts are fundamental to the organisation of specialist production when a business is producing goods or services (Weiss,1988:202). In general practice, co-operative effort is played out through the rhetoric of "teamwork". This was how teamwork was identified by a nurse who works in a rural practice:

> *The whole functioning of the medical centre, particularly in the rural area, could not exist without the work that the nurses do - we actually work as a whole team - we can't function without doctors and they can't function without us...and so it's this whole team process.*
> (Interview with nurse employed in a rural practice).

Most practice nurses understand that the "care" they give is complementary to care given by other members of the primary care team, and includes all aspects of their work. They speak of "care" in the sense of the total care available at one general practice rather than a particular procedure they might engage in as

nurse practitioners. This focus on "care giving" as the effort of a team can be problematic in that the work engaged in by practice nurses may be less obvious than that of other team members. There are often fluid boundaries between responsibility for some medical and nursing tasks. This makes it difficult to isolate those elements of their work which are considered strictly "nursing". This is illustrated by the distinction between "care" and "treatment". "Treatment" is usually given by the general practitioner and associated with prescribed medication. Many practice nurses take pride in successfully treating hard-to-heal wounds such as ulcers, and often work out of the "treatment room". This overlap with the work of doctors may contribute to the difficulty some nurses have in quantifying their work, in saying exactly what is involved in their contribution to general practice.

It is difficult to see health professionals as equal members of a team when one has to cope with competing demands in order that the practice of another is sustained. There were indications in the replies to the questionnaire that not all the nurses found this situation satisfactory. In response to an open-ended question which asked the nurses what they disliked about their work, some nurses suggested:

> *Lipservice is paid to teamwork by GPs*
>
> *... being treated as a Dr's handmaiden by some, instead of a complementary health professional*
>
> *... the lack of understanding by other health professionals (ie cervical screening programme, health administrators and planners at Regional Health Authority and Govt level) of the role of the practice nurse. At times we are overlooked, a recent example being a decision to improve vaccination levels by allowing Plunket nurses to administer vaccines without consulting with practice nurses.*
> (Responses to the questionnaire).

The last response indicates that being part of the primary health care team requires recognition from a wider field of organisations involving delivery of health care services, and not just the general practices within which practice nurses are located.

Ninety-seven per cent of the nurses who replied to the questionnaire experienced people asking directly for their services. If practice nurses work in areas where there are chronic illnesses due in large part to socio-economic morbidity, they can spend a lot of time advising and supporting people. However, even when the nurse has her own appointment times, the time she can spend with the patients who ask to see her directly is dependent on the doctor for whom she works. Another nurse explains that in her experience, although the patient prefers to see her, if the doctor has a patient who requires a nursing task then the nurse's consultation time with her client could be interrupted or cut short. Since doctor's time is more valuable to the clinic as a business, doctor's patients often have priority over nurse's patients, as this nurse explains:

> *Doctors sometimes consider the nurse's patients less important than their own yet all is done for the benefit of the doctor's patients - they all "belong" to him even if they prefer to see the nurse.*
> (Questionnaire reply from nurse based in a suburban practice).

This response indicates that while nurses see "their" patients, in the end it is the association of patients and doctors which is of crucial importance in the context of the business of general practice. The doctor decides which of the clinic patients will have priority, and the nurse as employee takes direction. Some nurses felt uncomfortable with the doctors' assumptions that as employees they would not only take direction, but they would also behave and respond in an expected manner. One nurse explains it in this way:

> *I dislike having to go along with the decision of the doctor concerned....when their decision is not to my satisfaction or disadvantageous to the patient.*
> (Response to the questionnaire from nurse in a suburban practice).

This response from the nurse in a suburban practice quoted above indicates that she thinks that the employment relationship restricts her from positioning herself as patient advocate, placing her in a contradictory and uncomfortable position. Her skills may be used as facilitator of the team, and to construct the medical

centre as a caring environment, but she is not able to see the problem through to what she would consider a satisfactory outcome. As subordinate, non diagnostic professional employee, she must appear to support the doctor's decision. This is similar to the analysis of "emotional labour" offered by Arlie Hochschild (1983). Nurses, like the flight attendants studied by Hochschild must, as part of their paid work, manage their feelings to create a publicly observable facial and bodily display. In the case of flight attendants this capacity to manage feelings is formally taught in training programmes. For the practice nurse it is informed as much by the rhetoric of "teamwork" as the requirements of the business of general practice. Relations among members of the team are characterised by unequal power in which the doctor's decision has priority.

4.4 Doing business, ordering supplies: practice nurses as resources for patients or doctor?

In all the practices I visited the practice nurses ordered the medical supplies. This includes treatment supplies like dressing and suturing materials, drug supplies, and appropriate containers for laboratory testing such as sterile jars for blood and urine samples. It is the practice nurse whom the retail seller of medical supplies will approach to demonstrate new dressing materials. Practice nurses see the area of wound and ulcer dressing as one of nursing expertise, complementary to medicine, so they see ordering appropriate supplies as nursing duties. Some nurses find that this places them in the position of considerable responsibility as one of the nurses explains:

> *I was the person who did all the ordering for the centre so that took a considerable chunk of my time - the medical equipment, drugs, dressings, everything you can think of. Sometimes the doctors would find something missing from their bags and take something from stock without saying anything about it...and then someone would go running to get an injection of something and there wouldn't be any. I used to try and get around one area when I had a few minutes and try and keep one jump ahead. I kept a check on the emergency box and the dangerous drug cupboard. I finished up with the emergency box by doing a whole listing of every drug in that box and its expiry date and putting that in the front of the box so that it could be seen immediately when something had expired.*
> (Interview with practice nurse employed at a suburban practice).

The nurse quoted above sees the importance of this work, although it takes up a considerable amount of her time. Some nurses find the organizational work demanded of them an impediment to their "nursing" tasks, especially planned preventive work[2] (Cowan,1995:74). Many practice nurses commented about lack of time. In their responses to the questionnaire they regretted being too busy to take advantage of opportunities for on-going education, or provide a wider range of nursing services. This raises questions about constraints associated with the public health and preventive medical tasks for which the practice nurse salary subsidy is paid.

4.5 The rhetoric of "family" medicine: transmutation of emotion work for the benefit of the business of general practice

The rhetoric of general practice still centres largely around the narratives of "family" medicine. After immersion in some general practices it is tempting to embrace Eva Garmarnikov's (1978) description of the "family-like medical triad" consisting of the patriarchal "father" doctor, the "mother" nurse, and the passive "child" patient, but this tends to obscure the complex set of social relations in these workplaces and ignores the part played by the Ministry of Health and the regional health authorities. Just as the traditional notion of the family as a "typical" nuclear family unit comprising a sexually cohabiting (married) couple, with the father the breadwinner and the mother caring full time for her spouse and their dependent children is no longer appropriate (Koopman-Boyden,1978:174), neither is the "triad" notion as applied to general practice. Five out of seven nurses located at the practices I visited during fieldwork worked for female general practitioners; and there were also several responses to the questionnaire from practice nurses which dispelled any generalised notion of patients as passive, for example:

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[2] For a discussion of the challenge practice nurses face in planning preventive work, see Stephanie Cowan, 1995, "Through the Eyes of a Shadow - A Peep at Practice Nursing from the Outside" in *New Zealand Practice Nurse*, February. p.74.

I find angry patients stressful when they feel they haven't got their moneys worth or complain about Doctor's fees.

I dislike dealing with drug addicts, I get sick of their manipulative ways.
(Responses to the questionnaire)

Nurses' assumptions about what people "need" is influenced by the bio-medical model in which they have been trained, a part of the bio-politics of the disciplinary society described by Foucault (in Rabinow,1984:283). In the "doing" of health promotion work practice nurses tend to be positioned as middle class regulators of people who are less than ideal health consumers. If a practice nurse decides people need medical care and refers them to the general practitioner, her work becomes part of a process of constructing people as patients/clients (Armstrong,1983:457-459) who may need to return to the medical centre time and time again. Seen in a economic sense, this is work of a public relations type which will benefit the practice, and it also establishes the process of continual regulation of the population.

The "dimensions of breadth and time" are said to be intrinsic benefits to general practitioners who operate as "family" doctors in contrast to consultants in "specialised" areas of medicine (Richards,1978:10). Care for the same patients over time is important in the running of general practices. It helps the practice accumulate background knowledge of inherited or recurrent medical conditions, and it allows the longterm establishment of the rapport and trust necessary for the "doing" of primary medical and health care. For many practice nurses, the relationships they nurture with people over time are personally satisfying:

I have especially enjoyed seeing and getting to know people over a period of several years, watching children grow up whom I have vaccinated since infancy.

I would say, without a doubt, that it is the most rewarding sort of nursing because of that ongoing contact...with the same people...it's quite unlike other nursing where you may see a patient for a brief time and then you may not ever see them again...you've seen them and you've seen their parents...often generations will come into the same practice.

(Questionnaire responses from nurses employed in suburban practices).

The commercial impetus to create long term relationships with patients/clients tends however, to give the model of private practice a different shape (Dingwall, Rafferty and Webster,1988:220). The establishment of longer term relationships also generates knowledge of social issues involving whole families, including financial circumstances. The provision of the General Medical Services subsidy means that the doctor is remunerated to some degree for a consultation notwithstanding the ability of the patient to pay. This arrangement allows a degree of medical discretion, an ideal supported by the profession as a whole[3] as it contributes to the ideal of personalised care.

In practice, although the doctor may write out the amount to be charged, it is usually the nurse or the receptionist who handle the money. The social and physical distancing of the doctor from financial dealings helps maintain a "professional" image, supporting the rhetoric of loyalty to the patient over and above the fee-for-service. However the fee-for-service is a fundamental part of general practice, and despite attempts to limit the fees charged[4], general practitioners have retained considerable control over remuneration. During the fieldwork many of the nurses said they disliked having to ask people for money. This was illustrated by the words used by a practice nurse when she charged the

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[3] In the Charter for General Practice, published by the Royal New Zealand College of General Practitioners in 1975, there is a section on remuneration which states:
5.1 The delicate doctor-patient relationship in the one-to-one relationship of the general practice consultation is best promoted by the patient accepting some responsibility for payment of the doctor, but this fee should never become an embarrassment or an impediment to free access to the doctor when necessary (Wright-St Clair,1989:80).

[4] In 1990 the government attempted to directly contract general practitioners, offering them higher medical benefits in order that the doctors restrict patient fees. The doctors strongly resisted the contract scheme.

grandmother of a little girl from whose arm she had removed a plaster:

> *I'm afraid I'll have to ask you for $7.00.*
> (During fieldwork in a rural practice, emphasis added).

Other nurses indicated similar feelings in their responses to the questionnaire:

> *I don't like taking money from sick and needy people.*

> *The most stressful aspect is not being able to provide for people's needs - political, financial constraints preclude some groups of the community from accessing the assistance which would best suit them ie user pays.*
> (Responses to the questionnaire from nurses employed in inner city and suburban practices).

Being in a position of having to ask "sick and needy people" for money interferes with the construction and reconstruction of the practice nurse as a "caring person" -someone who works to convey an atmosphere of caring and support. This becomes stressful when nurses feel that providing an atmosphere of caring is not enough to meet the perceived "needs" of the patients. Practice nurses may not identify themselves as having "a vocation", but many nurses ascribe to some of the unspoken assumptions related to vocation in nursing (Mackay,1992:32) especially the notion of meeting people's needs, and giving selfless service to others. Many of the nurses spoke about the extra tasks they did, the hour or two added onto their usual weekly time when they meet the rural transport delivering vital medicine or visit the mother with the new baby. Whether or not practice nurses are paid for this extra work depended on individual employers, but the nurses tend not to think of it as work for which they should be paid. In this sense they engage in work as "emotion work" rather than what Arlie Hochschild has described as "emotional labour" (1983:7). Hochschild describes "emotional labour" as emotion work which is sold for a wage in the public arena, work with exchange value, in contrast to "emotion work" which is performed voluntarily in private (1983:7). Women often "do" emotion work in the private sphere, managing people's feelings in domestic households. Practice nurses, who often do "emotion work" in their own homes, experience what Hochschild calls

"transmutation" (1983:7) when these relational skills are used for commercial purposes.

The element of "trust" is at the core of "emotion work", central to the "doing" of health care. There were many responses to the questionnaire in a similar vein to the one below which indicate the experience of others' trust was something most practice nurses enjoyed and gave meaning to their work.

> *I find most satisfying the trust that people have in nurses generally and will thus confide in them making meaningful contact possible in most situations in my job.*
> (Questionnaire response from nurse based in a suburban practice).

As women employees working as the employees of other health professionals, practice nurses are required to exhibit and produce high trust activities which benefits both the business of general practice and also the patients. This however, sometimes involves constructing practice nurses as carers in a gendered sense, rather than skilled, autonomous workers. At another level, involvement in the processes of taking money means that practice nurses cannot escape the business components of caregiving.

4.6 Maximising costs: utilising notions of nurses as guardians of health

Delegation of time for nurses to engage in health promotion activities benefits the business of the practice. It may take half an hour for a "well" woman to tell a nurse of some worry which necessitates her referral to the doctor for a consultation, as this nurse explains in an interview:

> **It strikes me ...in a sense your availability makes his practice what it is...?**
>
> *It does - it brings clientele as well as often they'll come in to see the nurse and they end up getting referred on anyway...typical thing is a Well Woman's Clinic - there are very few well women - as often they will come in with a nagging problem that they will tell you at the end when they've been with you for half an hour and they'll end up having to see the GP about it.*
> (Interview with nurse based at a rural practice nurse).

This quote highlights the contradictory position of many practice nurses. On one hand the nurse offers a Well Woman's Clinic organised around assumptions of wellness rather than illness, but contact with the nurse is a potential source of referral to the general practitioner. The health prevention work performed by this nurse is also work which generates fees for the practice. Another nurse working in a suburban practice, who also offers a Well Woman's Clinic, is required by her employing general practitioners to charge for her services and, although she can use her discretion over the actual amount charged, the service directly benefits the practice:

> **Do most women come because they're well or because they're worried about something?**
>
> *Most women come because they're perfectly fine but they've had that recall saying they're due for their smears so they come along and we go through the gambit of other things, and questions pop up and it can be half an hour.*
>
> **Can you charge them for that?**
>
> *It's a basic charge which is, if they've got a Community Services Card, depending on their circumstances, which I do know reasonably well with most of them because I've been here a long time, is either $10 or $15; and anyone who doesn't have a card it's $20 or $25 depending on their circumstances.*
>
> **So you're in a position to make judgements like that because you know people know you know their circumstances and the doctor trusts you to do that?**
>
> *Yes, but he pockets the money, I don't get it, it goes into the general practice funds - and I just get my basic pay, and it grates a bit because it's a skilled area...*
> (Interview with nurse based in a suburban practice).

Although this nurse is trusted by her employing doctor to charge patients fees which are "appropriate" for their circumstances, it is the general practitioner, and the patient, who benefit.

The importance of illness prevention, of encouraging individuals to be responsible for their own health, was echoed in all the practices I visited. An

important part of illness prevention are regimes of testing and immunisation. Practice nurses have responsibility for operating the recall systems, and checking results. If the practice is not computerised, the nurses keep manual registers for immunisation recalls. Most of the practice nurses I visited agreed with the views expressed at the 1994 National Practice Nurse Conference, where the nurses present were advised to construct themselves as serious, educated and knowledgeable people, able to discuss the issue and actively educate women about immunisation during ante-natal care rather than at the six week post-natal check as by then *it may be too late* (Margaret Eastcourt, speaking at the National Practice Nurse Conference, New Zealand Nurses' Organisation,1994).

Such dire predictions tend to exemplify the uncritical stance taken by some practice nurses over immunisation programmes. Sociologists argue that vaccination campaigns represent a further medicalisation of childhood, legitimating state surveillance of the population, particularly disadvantaged groups of society such as women, single-parent families, and minority ethnic groups (Dew,1995:2). Several of the nurses spoke to me of their reluctance to give an immunisation because the baby would inevitably cry on needle impact, but they concluded they had to be "cruel to be kind", showing their tacit support of the medical narrative that childhood diseases are a medical problem and, if untreated, constitute a social problem, one to be controlled (Dew,1995:18).

However, immunisation is also a useful tool to attract families with young children to the practice as potential clients. A practice nurse describes the way it works in the practice she works in:

> *We have a routine - if I do just an immunisation it's free, if I do other things like growth and development checks after that I pop them through to a side room and the doctor pops through and just checks their outcomes, anything I want checked and of course they GMS them, they charge a subsidy, which not everyone agrees with.*
> (Interview with nurse employed in a suburban practice).

This illustrates the close link between the policy requirement to immunise children against certain diseases, and the business of general practice, performed

by the practice nurse. Michel Foucault, in his discussion of power, describes the positions through which power passes (in Rabinow,1984:247). In this case the authority and experience of the nurse with her knowledge in child care could convince caregivers, bringing their otherwise well child to be immunised, that their child may need to be looked at in a more comprehensive way, and refer them to the doctor. The doctor can then claim a subsidy for confirming the child is developing normally. On the other hand, this procedure might lead to a defect such as hearing loss being picked up by the practice nurse. The gatekeeping practices of general practice would, in this case, necessitate a referral from the doctor to the hospital clinic for further testing since nurses are usually unable to refer patient/clients to specialist medical institutions.

As well as income, the generation of fees is seen as necessary to be able to afford modern equipment in order for the primary health care team to give the best possible care. In rural areas this objective is often reinforced by the voluntary setting up of a community committee in order to fundraise for expensive diagnostic equipment such as xray machines, and plaster saws, useful when catering for the accidents which characterise rural medicine. A general practitioner from a rural practice, in which I spent time during fieldwork, has divided the practice into two parts for purposes of management; the practice - which is the business part; and a second part called community services, which is non profit making, but which helps raise the profile of the practice in the community where the prospective patients reside.

A practice nurse at this practice was employed as Health Promotion Nurse one day per week in "community services" where she ran a "wellness" clinic attended mainly by women seeking help with weight reduction. The charges are kept deliberately low at $10.00, for the initial assessment lasting three quarters of an hour, and $5.00 for each successive visit. The nurse explained to me that the doctor, who had recently purchased the practice, wanted to become part of the community, but realised he would have to earn respect in order to achieve this.

By supplying inexpensive services through the practice nurse, the doctor consolidated the goodwill necessary for good business.

Some nurses feel ambivalent about the trend towards practice nurses generating income. This is illustrated by the following excerpt from an interview with one of the nurses:

> *If the subsidy goes we're definitely going to have to generate income so we're a feasible option to have.*
>
> **Have they been open in discussing this with you?**
>
> *Not so much in the way of if the subsidy goes - but in the general feeling that this practice is very much a business and it's the money involved. It is not so much that they'd want to push us out if the subsidy went but they'd want us to be generating an income.*
>
> **Do you get that feeling?**
>
> *Definitely...this practice is very money oriented...and building a building like this they would have to be...huge mortgages etc.*
> (Interview with nurse employed at a suburban practice).

In some practices practice nurses are required to charge for certain services:

> *When I say we charge that would be the people in Group 3, people who don't have a Community Services Card - blood pressure checks for people in group 3 - $5 -which the doctors feel is part of educating the general public that they are paying for a service the nurses are providing, they need to be prepared...that we are professional and we're entitled to charge too, we don't get the money in our pockets but it helps pay our wages I suppose, but it is a different way to a lot of practices - their feeling is that we're here to provide a service and the subsidy that gets paid is covering that but because it's only paying a portion of our salary they feel entitled that we can charge for that, adult vaccinations, travel vaccinations we charge for, part of that is the cost of the vaccination and part of that is the nurse's time.*
> (Interview with nurse based at suburban practice).

The use of the professional rhetoric to legitimise the entitlement to fee-for-service, promotes an ideal of the professionalism to which most of the nurses who participated in this study aspire. However, the use of "professional" in this sense is problematic. The "traits" seen as delineating a profession are usually

those characterised by the monopolisation of some form of expertise, the erection of social boundaries around them, and an ideology of public service and altruism (Abbott and Wallace,1990a:2), rather than economic self interest. The selective use of jargon associated with the corporate culture by the doctors who employ the nurse quoted above, to justify their requirement of the nurse to charge for certain services, is contradictory when considering the constructed invisibility of other aspects of the nurses' work which help sustain the business of general practice. At another level, taking a patient/client's blood pressure routinely could also be identified as illness prevention and health promotion work, for which general practitioners employing practice nurses receive a salary subsidy.

Some practice nurses are encouraged or required to have their own appointment times to see patients/clients, at a lesser cost than a doctor's consultation. I spent a day in a practice where the nurses work in ways similar to doctors with separate consulting rooms and appointment systems. If a patient's problem required attention from the doctor, the protocol was to call in the doctor who would examine the patient, perhaps prescribe, and claim the GMS, but the charge to that patient would be at the nurse's rate of $11.00 rather than the doctor's considerably higher rate. This tended to depend on the medical grouping of the patient. In this way, costs to patients were kept at a minimum. The nurses' 20 minute appointment times are longer than the traditional 10 or 15 minute slot allowed by most general practitioners. In this instance the nurse can make the decision to bring a doctor into the consultation with the knowledge that she is not wasting the doctor's charge out time nor generating extra costs to the patient. This consolidates her position as a caring person working on behalf of both the general practitioner and the patient. It also involves the practice nurses in "the balance of being in a business and being in the health business" (Simon,1994:35) in the sense of "gatekeeping for the gatekeepers".

4.7 Maximising "care": the element of discretion

The degree to which general practices adhere to discretionary action in terms of

modifying set fees-for-services differs from practice to practice. In all the practices in which I did fieldwork, the fees charges were modified in observations according to the circumstances of patients. In one of the practices I listened as a suburban practice nurse spoke with a young woman pregnant with her third child. The baby was due in three days and the mother had no one to look after her other young children while she delivered her baby in hospital. She had no partner, no family support, no transport, and very little money. Her last stay in hospital had been complicated by the judgemental assumptions of the hospital staff that the tattoos on her body meant she was a drug abuser, and she would now only see one doctor at the general practice and this particular practice nurse. The practice nurse spoke about how necessary it was for her to support this woman - this extended to transport and visiting her at home.

Both the doctor and nurse were impressed by the fact that this woman had had all her children immunised, this contributed to their view that she was a "Good Mother" and deserving of their support. It had been decided that the practice nurse would be paid by the practice for her attendance with the woman at the birth of her baby. The nurse told me the practice waived fees quite often if they knew people like this woman could not afford them. Discretion as to the charging of fees tended to be influenced not only by financial need but also by perceptions that individuals or families are "deserving". Other discursive practices in general practice allow practice nurses to exercise discretion for other reasons, as discussed by this nurse:

> **A lot of nurses have told me it's hard charging people...**
>
> *It is...with some people you don't find it hard, it's not a problem as long as you explain it to them...but other times I think "oh gosh, I really don't want to" .. we say we use our discretion...occasionally we don't charge for something which according to the way it's run we should.*
> (Interview with nurse employed at a suburban practice).

This nurse is making commercial decisions using a combination of knowledge of people's circumstances, and the altruistic values associated with the culture of

nursing, corresponding with the philosophy guiding practice nursing which states:

> it must be affordable, available, accessible and appropriate (New Zealand Nurses' Association Practice Nurse Division,1990:9).

While some practices charge for practice nurse services, others have decided that all nursing services will be free. Another nurse, drawing upon the discursive narratives of choice and access in health care provision, describes the way it works in her practice:

> *We've chosen not to (charge for services), and that was partly the doctor's choice but we agreed with it...in that doing that would actually inhibit people from using our services so they decided to include any unforseen costs into their consultation process to allow us to continue a free service and that's really for access for patients, for clients.*
> (Interview with nurse based at a rural practice).

The general practitioners for whom this nurse works have decided to absorb extra costs into their consultation fees. The doctors seem to think the presence of a "free" practice nursing service will generate goodwill among potential clients. The doctors can afford to make these kind of decisions as they have the flexibility to charge a fee-for-service, "commensurate with the service given" (Cole,1995:8), in addition to the General Medical Subsidy which they can claim for each consultation.

A different kind of example of the autonomous work of nurses within general practice is that of a practice nurse who has a successful part-time private counselling practice which is located within the rural general practice building where she is employed at other times as a practice nurse. The doctors who employ her as a practice nurse refer clients to her, as she explains:

> *My counselling work is my private work so while I get my referral from the medical centre I don't go back to them unless there is a particular issue, and I have always clarified that with the client...my counselling work is very separate ... they (doctors) have chosen not to ask me for rent because they actually want the service...they don't have the time and also they don't want to (do this work) - they've got their own particular interests.*

(Interview with nurse employed at a rural practice).

This nurse has formalised the skills of counselling which some nurses include as part of their everyday work. Through negotiation with the general practitioners who employ her, she provides a successful private service which in turn is of benefit to the general practitioners. The doctors find it useful to be able to refer a client to a counselling service situated in the same building, as they do not want to offer these services as part of their medical work. In this case, achieving an autonomous identity as counsellor rather than practice nurse is a crucial component of providing a convenient but separate service. In order to do this, this nurse has stepped out of the relationship of employee and set up her own private business.

4.8 Nurses as employees: the problem of specifying worth

Throughout the period of fieldwork the practice nurses told me they *knew* they were important for the individual businesses in which they were employed. Responses to the questionnaire however revealed that some nurses felt their work was not recognised as important, either by the doctors for whom they worked, or by monetary reward[5]. Such comments included:

No credit given for jobs well done.

Pay is really not enough for the job we do, we have a very responsible job and I don't believe we are compensated well financially.
(Responses to the questionnaire)

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[5] Practice nurses are the lowest paid community nurses, earning less than district nurses and public health nurses (Beckingsale,1995:27). The latest wage increase for nurses party to the National Collective is a 2.5% hourly increase to $15.82, 40 cent increase (announced by Kay Squires, Organiser, New Zealand Nurses' Organisation, 26th June 1995 at a practice nurse educational meeting). This is in contrast to Plunket nurses working for Plunket Line who are paid at an hourly base rate of $18.08 for work on Monday to Friday (this information was collected in a telephone conversation with Kay Galloway, New Zealand Nurses' Organisation, Wellington). Practice nurses may be employed under three different awards: an original award, individual contracts, or the National Collective contract. Some nurses do not have any contracts at all.

Many of the practice nurses are concerned at proposed changes in administration of the salary subsidy. At a meeting in August 1994, called to discuss matters related to lack of consultation with the Pegasus Medical Group over reform of health care delivery, the nurses discussed the forecast budget of Uncapped Primary Care Expenditure (Southern Regional Health Authority,1994). Although figures for the General Medical Subsidy, Maternity services, pharmaceutical, laboratory tests, diagnostic imaging, and incidental costs are all expected to grow, the figures given for practice nurses in 1992/3 ($6,405,000) is forecast to be slightly reduced in 1996/7 ($6,279,000) (Southern Regional Health Authority,1994). In comparison, the figure for pharmaceutical has a forecast growth of 8-9% from the 1993/4 figure of $150,907,000 to an anticipated figure of $189,145,000 in 1996/7. What does this mean for practice nursing?

I asked practice nurses about issues arising out of these projections and the extent to which they were being discussed with their employers:

> **What are you going to do if the subsidy is cut? Have you had any discussion with the GPs over that?**
>
> *No, not really...whether they will cut hours, I'm not sure. They know they need us and they have both said that. I'm sure they make good money. They'd be cutting their own throats and I certainly wouldn't take a decrease in pay - and I think decreasing our hours - we would still be taking a backwards step. I don't know, it hasn't really been bought up.*
> (Interview with nurse based at rural practice).

Many nurses seemed convinced that if the subsidy was bulk funded to an independent practices association on a permanent basis, the issue of "how much the nurses cost" the practice would be debated and this would be to the detriment of the practice nurses. As one nurse expressed:

> *It needs to be administered by another body or else it needs to be administered by a nurse in a nurses' group or by a manager, but not a doctor, and it has to be in a separate pot, else it will get lost...then they will start to talk about how much nurses cost. No-one ever talks about the costs the receptionists incur or the secretary incurs, its always the costs the nurses incur and I have a personal problem with*

> *that - no other profession...they don't have to prove how much their manager costs them. It's an attitude and that attitude has to go. As nurses we have to turn around and ask the doctors to define what they see the boundaries of nurses as, what are the boundaries that the nurses set themselves?*
> (Interview with nurse from an inner city practice).

This nurse seems to recognise the ambiguity and confusion generated over the shifting of professional boundaries along the lines of traditional practices such as "care" and "treatment". Her comments indicate that interprofessional flexible teamwork is only a notional ideal. This nurse would like the boundaries between the work of nurses, doctors, and receptionists, firmly redrawn, even bureaucratised, in an attempt to reduce the capacity of the general practitioners to use the nurses as they individually determine.

Yet the flexible boundaries between some medical and nursing tasks tends to make those tasks which are strictly "nursing" difficult to isolate. Moreover, the isolation of practice nursing has meant that measurement of performance outcomes poses a huge challenge. Responding to a question in the questionnaire which asked them to identify the aspects of their work they judged to be the most important, and on which they spent the most time, the practice nurses had difficulty in differentiating tasks. Some nurses saw all the tasks they did as equally important. Vicki Smith (1994:414) argues that performing "emotion work" distorts one's understanding of the boundaries between thinking how tasks should be executed and actually doing them. However, it is more likely that the construction of practice nurses as working with a "consciousness of competence", tends to mean that they assume they are available to meet **all** needs, not just those that could be categorised strictly "nursing".

4.9 The business of caring: conclusions

In this chapter the focus has been on the interaction between professional care and the business of general practice. The complex and often contradictory ways in which "care" is delivered in general practice often obscures the financial significance of practice nursing for the success of the individual businesses in

which they are employed. Relationally constructed as guardians of health, and sustained by the resilience of rhetoric such as "teamwork", the work of practice nurses is a key component of the partnership between primary care providers, and the regional health authorities' implementation of the health policies of the Ministry of Health.

Furthermore, the shifting boundaries between nursing tasks, and those which are considered "medical", performed within a relationship of employment, means that employers can use the subsidy to finance a variety of different forms of work by practice nurses. This includes reception, clerical, and cleaning work. Audit of the subsidy is only carried out as part of a complete audit of an individual practice, a situation which occurs only if deficiencies in terms of financial practices by general practitioners warrants attention. Such an audit would be concerned with hours of work performed by practice nurses, rather than specific duties[6]. However, current negotiations facilitated through the liaison committee[7] may result in the acceptance of a renegotiated job description for all practice nurses employed by doctors belonging to the Pegasus Medical Group. The draft description has been compiled by nurse members of this committee and, although it includes telephone work, it does not include reception, clerical or general cleaning work (Pegasus Medical Group, 1995).

It seems that practice nurses face difficulties in terms of specifying not only the boundaries of work they do, but also what their work is worth to the business of general practice. As one nurse said:

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[6] This information was collected through a telephone conversation with the Enquiries Clerk at the Christchurch office of Health Benefits Ltd.

[7] The "liaison committee" of the Pegasus Medical Group, comprising two practice nurses and two general practitioners, was formed in August 1995 in response to requests for consultation by the Canterbury Practice Nurse Section, New Zealand Nurses' Organisation. It replaced the former "steering committee" which was set up to discuss future directions for practice nurses employed by general practitioners who belonged to the Pegasus Medical Group.

We work so closely with our employers, it's hard to be militant.
(Practice nurse quoted in Manchester,1995:13)

It is precisely because the nurses work so closely with their employers, caring "for" and "about" both their employers as well as the people who use the resources of the practice, that they tend to be continually reconstructed as willing carers rather than skilled, autonomous, professional health care workers. The wages that practice nursing attracts are relatively low, and the present relationship of employment does not provide space for enhancement of a nursing role (Witz,1994) in the community setting. However, some practice nurses in Canterbury are quietly engaged in occupational strategies aimed at a redefinition of "teamwork". This is the focus of the next chapter.

CHAPTER FIVE

"SOFTLY SOFTLY": CONSTRUCTING COLLEGIALITY

> *I feel it is the <u>real</u> nursing job, the front-line community aspect, you see results - either positive or negative but it feels you're contributing to medicine in a real way.*
> (Questionnaire response from nurse working in a suburban practice)

During the fieldwork for this project, the notion of "teamwork" was used frequently by practice nurses and general practitioners to describe "ideal" working relationships within individual general practices. The concept of the "team" of health care professionals is referred to widely by both regional health authorities and members of the health professions as the preferred framework through which primary health care services are delivered (Toop,1995; Southern Regional Health Authority,1994; Turnbull,1994,1991). Articulation of this discourse of "teamwork" often includes assumptions that the "team" will be lead by general practitioners. In the previous chapter teamwork was discussed as a relationship of unequal power in which the doctor's decision has priority. However, an emphasis on the "subordinate" position of practice nurses neglects the occupational strategies which are being quietly pursued by some practice nurses.

Practice nurses are not only arguing for the importance of a team approach to patient care, they are organising strategically to redefine "teamwork". Deidre Wicks (1995:132) describes the availability of a structural "space" within the dominant biomedical discourse, a "space" in which nursing and "alternate" discourses can be nourished, mainly through the efforts of nursing peers and administrators. In the context of general practice, minus a nursing hierarchy and often without peers, some practice nurses are starting to articulate a "collegial" rhetoric which cuts across the traditional divisions of curing and caring. They are building on the notion of "teamwork", but asserting that their relations with general practitioners should be characterised by symbiosis rather than an

hierarchal division of labour. The rhetoric of collegiality is being utilised to construct practice nurses as actively involved as professionals in aspects of health care delivery, rather than just carrying out tasks under the direction of doctors.

This chapter explores the variety of ways in which the practice nurses who participated in this study articulated the practices involved in "teamwork". I begin with an analysis of the responses of some practice nurses to the notion of the "community" health care team. Their reactions indicate that some nurses are drawing upon their association with medicine to legitimate their place in general practice, a place which is based on an emerging belief that practice nursing constitutes a "specialist" branch of nursing, distinct from other forms of community based nursing. In contrast to the ways in which nurses' professional identity is usually constructed through a pivotal nurse/client relationship, practice nurses claim authority as professionals through their association with medicine. In the interests of articulating their identity in relation to that specified by other nurses, practice nurses tend to emphasize the doctor/nurse "team" and its particular benefits for the delivery of primary health care.

I also look at the ways "teamwork" is played out within general practice between nurses and doctors; and among practice nurses employed at individual practices. Although the work they engage in frequently crosses professional boundaries, most practice nurses tend to be explicit about their spheres of competence, but would like recognition that the work they do is complementary to that performed by general practitioners. Nurses who work in general practice claim involvement in social relationships of trust with both patients/clients and general practitioners. Practice nurses also emphasize the value of practical skills learnt through their daily work, relative to knowledge learnt from formal training and textbooks. This is reflected in the desire for greater recognition of the skills they acquire on the job, and is the basis for their pursuit of formal accreditation for their specialty within nursing.

There are sometimes divisions among practice nurses working at the same

practice as to the importance of certain skills, divisions which tend to reflect different times of entry into training. These differences heighten the difficulties associated with the construction of a united identity as practice nurses and the political implications which this entails.

Finally, I explore the way nurses use "teamwork" discourses as an occupational strategy, or a particular "professional project" (Witz,1994). The use of the term "collegiality" is integral to this process. Collegiality has become a rhetoric utilised by practice nurses involved in the New Zealand Nurses' Organisation and in articles about practice nursing (Hounsell,1992; Stodart,1994; Beckingsale,1994; Collins,1996).

5.1 Theorising "teamwork"

Anne Witz (1994) makes a distinction between the sort of work which constitutes an "enhanced nursing role" - one advocated by the "new" nursing - and an "extended nursing role", one which enlarges the nurse's sphere of competence by incorporating medically approved tasks. This is useful in light of Andrew Abbott's (1981:190) use of the concept of "jurisdiction" to focus analysis on the link between a profession and its work. The notion of jurisdiction refers to claims of professional expertise necessary for particular work, claims which may be contested by other professional groups. A consideration of jurisdiction is useful when considering occupational strategies of credentialism presently undertaken by practice nurses, strategies which seek to define and institutionalise the distinctive knowledge base of practice nursing (Witz,1994:23).

Abbott argues that professions do not develop interdependently of one another (1988:90). He describes a "system" of professions with only so many jurisdictions to go around, which results in professions like nursing having to accept what he calls a "limited settlement" (1988:72), an agreement not to infringe on the jurisdictional field of a more powerful group. Nevertheless, he suggests that maintenance of settlement by division of labour is difficult (1988:74). This is also problematic for management of health professions by state authorities who tend

to utilise the rhetoric of "teamwork" to manage contested jurisdictional claims.

"Teamwork" implies professional interdependence, with all members of the team relating to, and respecting, the knowledge each contributes. The ideal is that patients/clients should have access to a system of co-ordinated professional services which ensure competent diagnosis and treatment. Health managers are interested in "teamwork" as a way of ensuring that public funds are not mismanaged through the monopolistic interests of one professional grouping. Through practices of complementary work practice nurses are working across hierarchal professional boundaries. Rather than making specific jurisdictional claims, they are utilising an **inclusive** rhetoric of "teamwork". This contributes to the construction of general practice as the ideal nexus of primary health care.

5.2 Cohesive or divisive? Practice nurses within the wider community team

For practice nurses the primary health care "team" is the general practice "team" rather than the wider community based health care team which includes practitioners such as pharmacists, physiotherapists, social workers, midwives and Plunket nurses. However, practice nurses may have frequent contact with some or all of these practitioners in their daily work. One practice nurse with whom I spent time during the research process spoke eloquently of accessing people from the rural community in which she was based, but these people were more likely to be those who could offer patients spiritual support, or caregivers who could ensure that a person with a terminal illness could be nursed at home, rather than workers in related health care occupations.

The notion of "teamwork" in terms of the wider community health care team is a key component of the vision promoted by the Southern Regional Health Authority for the future of primary care (Southern Regional Health Authority,1994:6). Tessa Turnbull, writing in 1991 as Chairperson of the Royal New Zealand College of General Practitioners in response to the introduction of market philosophies into health care, suggests that "the team of health co-professionals with complementary skills... working from a general practice base",

is the answer to the problems of the delivery of health care (1991:519-20). How effective in practice is this rhetoric of "teamwork"? Is the concept of teamwork viable while doctors continue to exercise control over the work of other health professionals, especially in contexts like general practice in which doctors are small scale entrepreneurs employing practice nurses?

The Christchurch Teamwork in Primary Care Study (1995) explored the level of interdisciplinary contact between different community based health care professionals working within the Christchurch urban area. The authors found a degree of apparent unanimity about the desirability of closer collaboration, even though one quarter of general practitioners were concerned with the effect that collaboration with other health professionals would have on their income (Toop,1995:6), an indication of the tensions existing between the rhetoric of teamwork and the commercial interests of private businesses. Although the study concluded that relationships between health professionals in the community appeared to be generally well developed, there were several nursing groups, including Plunket nurses, district nurses, midwives and public health nurses, who indicated a preference for significantly more collaboration with general practitioners than they were currently experiencing (Toop,1995:3). The study recorded that "practice nurse representatives had noted that their levels of contact with other nursing groups could be improved" (Toop,1995:9).

Does the positioning of nurses in general practice affect the contact general practitioners have with other nursing groups? Dr Selwyn Carson, a general practitioner from Christchurch, generalises from his own experience that:

> General practitioners find it difficult to delegate responsibility over the telephone, through a chain of officials, to a District nurse who is unknown to the general practitioner and who may be in the job for a week or two and responsible to an organisation other than the practice (1978:80).

This opinion points to difficulties of collaboration and delegation with nursing groups outside general practice and suggests doctors are more likely to form relationships of trust with nurses within the practice and working daily under the

direction of the general practitioner. Such relationships enable most practice nurses, particularly in rural practices, to "cover" for the doctor in the sense of dealing with enquiries of a medical nature when the doctor is consulting or visiting. This interdependence of nurse and doctor is sustained by the doctors' experience of practice nurses referring people directly to the surgery for medical advice.

While practice nurses and doctors may be explicit about their interdependence, nurses do not always experience such interdependence with other nurses, especially nurses outside their practice. **Sixty-nine percent** of the nurses who responded to the questionnaire administered to practice nurses in Canterbury indicated that they worked with other nurses in the community, but this tended to depend on the location of the practice. Nurses who work in rural general practices worked most often (77%) with other nurses in the community, often *liaising with and relieving for district nurses* (questionnaire response from nurse employed at a rural practice), reflecting the implications of geographical isolation and the necessity for some nurses to wear several hats. Nurses who work in suburban practices also worked with other nurses (65%), but some of the nurses qualified their response by saying they worked with other nurses in their practices. In contrast, 73% of nurses who worked in inner city practices indicated they did **not** work with other nurses at all. This may reflect contact with fewer elderly clients, or young families, who are less likely to attend inner city practices and most likely to use community nursing groups. It may also reflect a form of gatekeeping engaged in by some practice nurses in terms of protecting their specialty area.

During the period I spent in observation in general practices some nurses grumbled about what they saw as encroachment on their territory by other nursing groups. The nature of this was illustrated during an interview with a suburban practice nurse who explained:

> *The District nurse, we're having much more liaison but we're still finding that they're going to do a dressing - three days down the line they'll ring and say "look we're a bit concerned about this, it's not*

> *looking so good". And it's actually been a week since it's been obviously infected and they've carried on, and then they still don't realise we must see it to assess just what's been happening and that's a major concern. We got one the other day that we had to put into hospital as it was too far down the line to correct. It needed IV antibiotics and such - so there's still that problem. Of course the Public Health Nurse is another problem again because everything that they do they're not letting us know. They went through the local schools and did all the MMRs (Measles, Mumps and Rubella Immunisations) and didn't let us know and we're supposed to be the medical back-up for our local school. The only reason I knew was one of the mothers rang and said would you do so-and-so? That's not good - it has always been that way unfortunately.*
> (Interview with practice nurse employed in a suburban practice).

In this portion of the transcript the practice nurse uses the word "we" in the inclusive sense of the doctors and nurses with whom she works in general practice, positioning herself in terms of her association with general practice as the legitimate site for the treatment of infections and potential reactions to immunisation. This claim of jurisdiction (Abbott,1988) exists somewhat in tension with the more usual association of practice nurses with issues of health and wellness rather than the treatment of illness. It illustrates how some practice nurses "do" their identity through the utilisation of shifting alliances in different contexts, and in this way consolidate their position within general practice. This nurse provides an argument for the occupational authority of practice nurses while at the same time arguing for the exclusion of her nursing colleagues from certain tasks on the grounds of their lack of knowledge of current treatment and their lack of association with medical colleagues. In the process of establishing boundaries between work done by nurses in the community and tasks needing medical attention, she is constructing general practice as the ideal nexus of primary health care delivery and aligns herself with the doctor/nurse "team" rather than the nurse/nurse "team".

Indicative of practice nurses' sense of location in a unique general practice based health "team" was the response by some practice nurses to the suggestion that "a generic nurse" position be established in the community, one who could co-

ordinate community nursing groups from a general practice base. This possibility was raised at a meeting in August 1994 called by members of a steering committee of local nurses, set up to discuss future directions for practice nurses with members of the Pegasus Medical Group. The practice nurses present assumed the co-ordination of nurses would be their job, and voiced strong objections - *practice nurses*, they said, *could not be expected to do all the work, they were not wonderwomen* (Meeting notes,16.8.1994). The establishment of such a position, they felt, would have the potential to *pit nurses against other nurses*, which may *lead to the loss of specialist nurse positions* (Meeting notes,16.8.94) such as Plunket and district nurses and, although they did not say so, presumably practice nurses. These practice nurses wanted to preserve their occupational specialty, based in general medical practice, rather than have this diluted through working with community nursing groups on a range of nursing tasks. The notion of "a generic nurse" was particularly threatening in a context in which registered nurses have been replaced with lower status "caregivers" (O'Connor,1993/4).

The desirability of being associated with medicine, the belief that practice nursing is **the real nursing job** in the community, was also indicated by a practice nurse in her response to the questionnaire:

> *I feel it is the real nursing job, the front-line community aspect, you see results - either positive or negative but it feels as if you're contributing to medicine in a real way.*
> (Questionnaire response from practice nurse based at suburban practice).

The claim that nursing is experienced as "real" in the community if it contributes to medicine is contradictory to the nursing ideal of being likened to a travelling companion who possesses specialised knowledge and skills which she shares in a partnership with the patient/client (National Action Group,1987:4). It reinforces the notion that the primary orientation of practice nurses is to the nurse/doctor relationship, rather than the nurse/patient/client partnership.

5.3 "Teamwork" within general practice between nurses and doctors

During fieldwork in general practices I was exposed to a variety of stories about teamwork. One nurse, employed in a rural practice, spoke with enthusiasm of feeling part of a system which she likened to an active wheel, revolving around the patient. Another nurse, from an inner city practice, expressed frustration at not being able to be useful in areas in which she felt she could make a meaningful contribution. In some practices the reality of hierarchal relations of work were seen as something which inhibited the achievement of the ideal of teamwork. In her response to the questionnaire, one nurse wrote:

> *The practice here works with a manager, nurses, GPs and receptionists and not as a team and very little communication between groups.*
> (Questionnaire response from practice nurse employed in a suburban practice).

Working relationships between some practice nurses and doctors contain complex and contradictory elements, centred around professional boundaries and debates of jurisdictional claims which impact on the quality of some "teamwork". Most practice nurses are explicit about their spheres of competence in the primary health care team, arguing their practice is based on health and wellness rather than sickness. Robyn Beckingsale, a practice nurse from Nelson, has written:

> I have never yet met a practice nurse who wants to be a doctor, but I've met plenty who wish their nursing skills were taken seriously (1994:37).

Throughout the research process many practice nurses spoke in similar ways of instances which highlighted the lack of recognition of their skill and knowledge base. This was often expressed as problems with "attitudes". This was the way one nurse answered a question relating to what she would like to change:

> *I would like (to change) doctors' attitudes towards working with nurses. Doctors constantly not recognising nurse's qualifications and years of experience.*
> (Questionnaire response from nurse based at a suburban practice).

The superior "attitudes" of doctors referred to by many practice nurses, and other health care professionals (Toop,1995; Georgian Research Society,1991), are a component of the interprofessional tensions which Andrew Abbott (1988:81) argues are necessary conditions for the maintenance of claims of full jurisdiction. Some doctors view the presence of nurses in the practices as a threat to their professional autonomy, indicating paradoxically that nurses' skills are indeed taken seriously. This is recognised by Dr John Richards, who suggests that:

> Traditionally, GPs have been taught to regard themselves as being "all things to all men" (sic). Doctors may see the intervention of a third party in the doctor-patient relationship as a threat to their self-image and to their status (1981:22).

Practice nursing was established in New Zealand as an occupation in 1970 in response to a national shortage of rural doctors. Although the nurses were expected to only perform "the more routine tasks in rural practices, freeing the doctor for tasks only he/she could do"[1] (Hounsell,1993:3), some primary health care analysts forecast a more proactive role for practice nurses as is suggested by S.C. and M.C. Thomson, writing as early as 1974:

> The image of a responsible practice nurse...able to take responsibility for jobs delegated by an overworked GP..is a viable one consistent with other trends apparent at this time...Such a responsible better trained nurse, rather than be threatening, could in the future invite increased consumer participation in both the planning and effecting of a health service in the community (1974:84/85).

In a chapter entitled "The general practitioner as the leader of the health team" (1978), Dr Selwyn Carson addressed issues relating to confusion between the responsibility of nurses and doctors:

> The truth is that nobody yet knows what the practice nurse may be required or expected to do. Most practice nurses are probably not suited to the hospital hierarchal system and are not submissive

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[1] The New Zealand Census of Population and Dwellings of 1971 gives a figure of 6.4 per cent of general practitioners as female. By 1991 this had risen to 22.2 per cent.

> people... doctors and nurses have inappropriate training and, when they try to work together in general practice, there is role conflict. It is as difficult to change the general practitioner into accepting the nurse as a colleague and to make proper use of her training and ability as it is to get the nurse to abandon her role as a subordinate who stands with her hands behind her back, waiting for the doctor to tell her what to do. (1978:78-79).

Dr Carson identifies the potential for collegial practice, and is critical of the "subordinate" role of nurses. Dr John Richards, writing about the role of the practice nurse in a chapter entitled "New developments in community care", suggests:

> Some (doctors) even feel that their whole place in the provision of health care is at risk. Most patients appreciate personal care with a one to one relationship with their doctor, but many people fail to realise that this is just as important for the doctor as it is for the patient...another threat perceived by some is that the practice nurse may effectively reduce the doctor's income (1981:22-23).

It is difficult to see how the provision of a nursing service could affect the doctor's income in a detrimental sense as the general medical subsidy is made available only to the doctor, and only if he/she has actually seen the patient. In this sense, legal relations between general practitioners and practice nurses are fixed. Even if the nurse was to see large numbers of patients independently of the doctor, she would not be able to claim a subsidy. Nor is she able to prescribe medication other than that which can be purchased from a retail pharmacist, or refer patients to medical consultants or to laboratories for medical tests. As for public relations, such is the general confidence in the trustworthiness of doctors that the salary subsidy paid to general practitioners has never been monitored for abuse (Hounsell,1993). The signed declaration by both practice nurse and general practitioner that the duties carried out were in fact nursing duties was thought sufficient deterrent by the local area health boards and, currently in Canterbury, by the Southern Regional Health Authority.

Indicative of what practice nurses refer to as problematic "attitudes" was the preemptive handling of the pilot fundholding budget by the Pegasus Medical

Group and the Southern Regional Health Authority. In August 1995 the chairperson of the Canterbury Practice Nurse Division learnt, quite incidentally, that the practice nurse salary subsidy had been effectively paid in bulk to the Pegasus Medical Group since the 1st June 1995, without any consultation with the practice nurses concerned. The nurses were dismayed, but not surprised. At a meeting in August 1994, called by practice nurse members of the "steering committee"[2], the thirty practice nurses and two New Zealand Nurses' Organisation officers present had been alerted by members of the "steering" committee to the doctors' desire to have the funding for the salary subsidy paid directly to the Pegasus Medical Group (Meeting notes,16.8.94).

However, none of the nurses present at this meeting volunteered to join the working party suggested to explore the issue of remuneration. In an attempt to explain her refusal to volunteer one of the practice nurses said: ***we're nurses, not politicians*** (Meeting notes,16.8.94). Her words seem to encapsulate the tensions some practice nurses feel in maintaining their often precarious position in general practice, conscious that formally articulating their interests as practice nurses may impinge on "team" relations negotiated informally within particular general practices. While the nurses who co-ordinate the local New Zealand Nurses' Organisation committee sometimes complain about the abundance of what they perceive of as "apathy", throughout the period of observation in general practice I continually observed the informal negotiations and jurisdictional claims reported elsewhere in this thesis.

The successful negotiation of bulk payment of the practice nurse salary subsidy by the Pegasus Medical Group suggests that the role of practice nurses in the restructuring of delivery of primary health care is primarily to be decided by this

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[2] This was the name of the committee of local practice nurses set up to discuss future directions for practice nurses employed by general practitioners who belonged to the Pegasus Medical Group. This particular meeting was called by the nurses on this committee who had been recently updated by representatives of the Pegasus Medical Group on recent negotiations. This committee has now been disbanded.

group of medical practitioners rather than the practice nurses themselves. The contract between members of the Pegasus Medical Group and the Southern Regional Health Authority defines practice nurses and general practitioners as "subcontractors" (Pegasus Medical Group,1993:3), which appears to lessen the chance of the regional health authority directly intervening in the relationship between doctors and practice nurses. It will give the doctors tighter control over the services they want the nurses to provide, and the means to pay for those services. The exclusion of nurses from the negotiation of this contract appears to be a strategy directed at reducing any claims of jurisdiction which practice nurses might want to make. It reconstructs general practitioners as team leaders in the primary health care field - leaders of a team who subcontract work to practice nurses.

At the same time, the definition of practice nurses as "subcontractors" implies that practice nurses are an independent autonomous group, available to negotiate a contract, or contracts, with general practitioners to provide a nursing service. This is problematic as the only contract practice nurses enter with general practitioners is one of employment, an entirely different concept. Their identification as "subcontractors" also implies that practice nurses were a party to the contract. Although the nurses on the "steering committee" offered to accompany the doctors to the discussions with the Southern Regional Health Authority, these offers were repeatedly declined (Meeting notes,16.8.94). It seems as though being defined in this way in a contract is more likely a mechanism to enable bulk funding to the Pegasus Medical Group. However, a definition as "subcontractors" offers potential for practice nurses to collectively contract their nursing services. This depends on them organising as group and practice nurses refusing to accept contracts which fall outside the one agreed on by their organisation.

Declarations of jurisdiction by general practitioners are often accompanied by claims of ultimate responsibility for the treatment of illness. Hardly any of the practice nurses in my study would take issue with this precept that doctors

diagnose and treat illness. This enables the nurses to practise skills which have become common to both doctors and nurses, such as taking cervical smears, without taking responsibility for treatment if the result is not clear. Throughout the research process many nurses spoke of this responsibility as a heavy one, and one which they did not envy. Nevertheless, **thirty per cent** of the nurses who responded to the questionnaire indicated they were interested in extending into the medical and diagnostic areas of medicine, and a recent feasibility study of a practice nurse established as a minor illness nurse in England concluded that:

> trained nurses could diagnose and treat a large proportion of patients currently consulting general practitioners about minor illness provided that the nurse has immediate access to a doctor (Marsh and Dawes;1995:163).

While practice nurses are not traditionally involved in diagnosis, it became apparent during this research that in a number of workplaces the content of some nurses' work approaches a high degree of responsibility for medical treatment. A practice nurse from a rural practice spoke of what she is able to do for ill patients:

> *If someone comes in with chest pain and the GPs away I'll put the oxygen on and do an ECG and a workup and if I'm not happy I'll ring him and say I'm going to call an ambulance and (the GP) will back me up the whole way..and if I don't agree with them (the GPs) I'll tell them too, nicely.*
>
> **Would they mind?**
>
> *No...they're very good like that and they'll often ask what I think...or I tell them in a nice way.*
>
> **So is it like a team approach do you feel?**
>
> *Yes...probably because I respect them both as doctors...I couldn't work for someone I didn't respect as a doctor...yes, we all work well as a team.*
> (Interview with practice nurse based at rural practice).

This nurse is trusted with performing elements of medical care in the sense of making a preliminary diagnosis and calling an ambulance, not a decision to make

lightly in a rural area where the ambulance has to come out from town, or is staffed by volunteers who have to be called from their work. In this instance she uses the notion of "respect" in much the same way as general practitioners use "trust", to indicate that it is a necessary factor for inclusion in a functioning health care team. The initiative this nurse shows is related to her structural positioning in a rural practice with expectations that she will cover for the doctor at certain times, but she suggests that she may challenge decisions made by doctors and expects her working relationships with doctors to be collaborative.

Another practice nurse, working in a suburban practice, routinely performed the suturing after her employing doctor had completed minor surgery. During the period of fieldwork in this practice I watched the doctor remove a mole, and then allocate the suturing to the nurse. This doctor made reference several times to the nurse's expertise in suturing, and his gratitude that she was both willing to, and skilled at, performing such a technical procedure. In this practice, and in the case of the rural practice described above, it seems the working relationships are significantly characterised by the collegiality implied by the rhetoric of "teamwork".

Both these nurses are trusted to perform elements of medical care, and work in ways not dissimilar to the practice nurses who run a thriving practice at Eketahuna in the northern Waiarapa (Brash and McClellan,1989). In 1988, when she had to vacate the position, the small rural town's sole general practitioner suggested to the Health Department that more could be made of the two practice nurses[3]. With support from the local County Council and links with general practitioners 26 kilometres away, the two nurses set up a health centre. When their service was evaluated in 1989 the authors of the evaluation noted:

> There appears to be a mutual respect between the Pahiatua doctors and the Eketahuna practice nurses in regard to each

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[3] This information came from an address given at the National Practice Nurses' Conference, by Anne Davies, one of the two nurses from the Eketahuna Health Centre, at Auckland in April, 1994.

> other's knowledge, skills and expertise. In June, 10% of the nurses' caseload required discussion over the telephone with the doctor(s). However, the frequency of telephone consultations has subsequently declined as the nurses' confidence and experience has grown (Brash and McClellan,1989:21).

This situation has interesting parallels with the establishment of practice nursing in the context of a national shortage of rural doctors, and illustrates the potential of practice nursing to offer a cost effective service.

Another practice nurse, based at an inner city practice, used the term "collegiality" during an interview to describe her role as case manager and how she sees this affecting her working relationship:

> *Because of this position (of case manager) I have the flexibility, not only to go into the homes and do assessments, but I have the autonomy to actually pick up the phone and access agencies as I see fit...naturally I always feed that back into the practice, or work to the doctor's directive, so as I see it, it's a real collegial relationship.*
> (Interview with practice nurse employed at an inner city practice).

This nurse operates with partial autonomy which she sees in a symbiotic sense, working in a relationship of mutual interdependence with the employing general practitioner. Her work description is specific in that it is concerned with education and health promotion rather than with clinical tasks. She tends to distinguish herself from the other practice nurses in the clinic where she works, nurses who are more concerned with clinical tasks. In an interview, she articulated the difference between her work and that of other practice nurses in the practice:

> *I haven't given an injection for five years but I would give a few sips of polio if the child was with me but I refuse to give injections...it's a matter of boundaries*
> (Interview with practice nurse from an inner city practice).

It appears that this practice nurse considers that being involved in clinical tasks helps to maintain a "subordinate" positioning for the other nurses in the practice

and reduces their likelihood of practising in a "collegial" relationship. Her achievement of a "collegial relationship" with doctors however, may be at the expense of collectivity with other nurses. The creation of opportunity for collegiality with doctors may therefore replicate divisions found within the wider field of nursing, particularly those between managerial type positions and those commonly called "hands on".

5.4 "Teamwork" among practice nurses within general practice

In profiling practice nurses Robyn Beckingsale, the practice nurse from Nelson quoted above, writes:

> Probably most practice nurses are in their thirties or older, perhaps not as outspoken as their younger polytechnic trained counterparts...The much maligned Polytech nursing courses are probably producing nurses with a greater awareness of their individual personal worth - whatever criticism we level at their skills!
> (1995:37)

The rhetoric of "hands-on" style training was frequently used by many of the practice nurses in my study who had trained, as I did, under the apprentice style hospital training scheme, in contrast to the training currently received through Polytechnics. Practical skills, such as working gently but efficiently when dressing a painful wound, and "intuitive" skills such as realising when a patient/client may be heading for a diabetic coma, were emphasised among student nurses during our training as being of paramount importance. In the 1960s a nurse who dared to be "outspoken" was considered counter productive rather than assertive. Co-operating with all the nurses on each shift was imperative to ensure all the nursing tasks were achieved, critical in a ward where one needed at least two nurses to turn a paralysed patient. One practice nurse identified the differences attributed to the two methods of training in this way:

> *That's why I left Christchurch Public...I got to the stage as a senior staff nurse working with young girls coming through Polytech, they are very qualified, they have got a lot of theory but they have no eye skills, no practical skills, and I think you need these before you start on anything else. There's still the good ones...but there is a big gap.*
> (Interview with nurse from a rural practice).

In contrast, younger nurses suggested that older nurses, trained through the hospital system, resisted change. A younger practice nurse, aged 24, who trained through the Polytechnic, complained that the older nurses (all over 50) resisted the changes she wanted to make, especially the use of new methods of immunisation, and different antiseptic cleansers. She also responded negatively to the institution of practice nurse meetings, which she described in an interview as ***bitch sessions***. This younger practice nurse had married the general practitioner for whom she worked. This may well have intensified the barriers between her and the other practice nurses and undermined the innovations she sought to achieve.

The tendency among nurses to emphasize differences between nurses has been documented as a form of "horizontal hostility" (Roberts,1985). Some analysts have argued that this "horizontal hostility" arises out of the subordinate status of nursing relative to medicine. However, this analysis of "horizontal hostility" tends to assume that nurses are homogeneous and neglect the divisions within nursing. Bryan Turner applies the notion of "vocabulary of complaints" to nursing, arguing that it forms part of a discourse which articulates a subcultural perspective within an occupation, providing a sense of social solidarity among lower order practitioners (1986:369).

I suggest claims of jurisdiction, including practical "eye" skills, are more usefully seen as claims for informal credentials useful in the workplace, an indication that some practice nurses are as concerned with constructing practice nursing as an occupation with certain specialised skills as they are with the interface between nursing and medicine. In this respect they are looking for recognition of specific skills and knowledge learnt through experience on the job, reflected at the political level in the continuing desire for accreditation, as recognition that a nurse:

> ... has mastered a body of knowledge and acquired skills in a nursing specialty (Trim,1995:11).

In these respects some practice nurses are working towards a professional practice which Witz (1994:29) has described as being a "knowledgeable doer", emphasising professional competency and individual judgement in applying principles to practice. This mirrors the professionalising strategies of doctors and divisions between medical specialties.

At another suburban practice, where I spent some time during the research, the six full time practice nurses had initiated a weekly meeting, after negotiation with their employing general practitioners, in an attempt to promote communication between nurses and provide mutual support in particular areas, such as asthma education. The practice nurse who identified as the "head" practice nurse spoke to me of her belief that many practice nurses were women who had been trained to be submissive instead of believing that ***they could do anything they were trained to do***. Some practice nurses, she said, say they are busy but they are doing ***trivial duties***, filling up their time with things they see need doing, but not necessarily by a nurse. In Abbott's (1988) terms, they do not want to persevere with jurisdictional claims since their current jobs are consistent with other demands on their time at a particular stage in their lives.

At a meeting in June 1995 I spoke to practice nurses about the research in process and mentioned that all the nurses who participated in the study were female. I had been informed by the members of the Divisional committee that there were no male practice nurses in Canterbury. I was corrected by one practice nurse who spoke of the existence of a male practice nurse. An argument then ensued between this nurse and other practice nurses present, in particular those nurses involved in the Nurses' Organisation, who said this man was not considered a practice nurse as he was also a manager of the practice concerned. This suggested that being named as manager was inconsistent with being a practice nurse. While practice nursing contains many managerial and organisational aspects relevant in the maintenance of the business of general practice, this aspect of their work was not emphasised by the practice nurses who participated in this discussion, despite their interest in the theme of the evening

"celebrating our diversity".

While practice nurses may identify with the ideal of celebrating diversity, such diversity may be problematic for the construction of a united identity as a specialty within nursing. However, the rhetoric of "collegiality" used by practice nurses accentuates symbiotic social relationships which mutually benefit the members of connected interest groups such as doctors and nurses rather than relationships among nurses. As such, the emphasis is on the combined medical and nursing interest rather than traditional nursing interests only.

5.5 Collegial practice: a professional project? "Teamwork" among practice nurses interested in professionalising strategies

A month after the change in administration of the practice nurse salary subsidy had come into effect the Chairperson of the Canterbury Practice Nurse Section wrote to the Pegasus Medical Group seeking formal consultation. In response to this request a liaison committee has been formed, comprising two practice nurses and two general practitioners. In a letter written to their medical colleagues, the doctors involved explained that such a committee would enable a more accurate picture of the practice nurse salary subsidies and applications. They also expressed hopes of establishing better lines of communication between practice nurses and the doctors who belong to the Pegasus Medical Group[4] (McCormack and Hudson,1995). The careful and non confrontational response of the practice nurses to the subsidy regime recognises that, while constraining in opportunities for independent practice, the new circumstances could enable significant gains in terms of establishing practice nursing as a nursing specialty. The very real frustration some nurses felt at the lack of consultation could engender a stronger sense of collectivity among practice nurses than previously

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[4] Nearly 200 general practitioners in Canterbury currently belong to the Pegasus Medical Group (Manchester,1995:14). The high membership is due to credibility of key medical staff associated with Pegasus. Most of these doctors are also involved with the establishment and management of the co-operative After Hours Surgery in Christchurch.

experienced, which may be helpful in establishing a greater sense of the collective interests of practice nurses. Feelings of frustration among practice nurses has forced the doctors to establish a line of communication. Practice nurses now have a formal mechanism which they can use to construct practice nursing as a nursing specialty. It is in the doctors' interests that this specialty is defined through it's close association with medicine rather than autonomous nursing practice.

In this sense there is a conjunction of interest between practice nurses and general practitioners. The nurses on the liaison committee of the Pegasus Medical Group are now drafting a job description for practice nurses which will have to be approved by the executive committee which consists solely of doctors. The nurses have drawn up worksheets containing a list of tasks, which would be used to assess newly employed or prospective practice nurses. These aspiring practice nurses would be assessed by "an experienced practice nurse" (Pegasus Medical Group,1995). Although this is being pursued in conjunction with their employers who are able ultimately to control what tasks go on the list, this is an attempt by the practice nurses to define and institutionalise a distinctive knowledge base. The definition of professional boundaries, and standardisation of jurisdictional claims, was not possible when nurses performed tasks set by individual employers who, although subsidised to utilise the nurses they employ for specific purposes, had considerable control over the work of practice nurses.

Paradoxically, this will tend to replicate aspects of the nursing hierarchy most practice nurses said they were pleased to escape. Other nurses have already suggested the need for a supervising practice nurse position to monitor the subsidy and the nursing services given in general practice (Hounsell,in Stodart,1994:17; Beckingsale,1994). In October 1995 the Pegasus Medical Group appointed a former practice nurse to the newly established position of Immunisation Co-ordinator. A job description for a pilot position of Practice Nurse Quality Assurance Facilitator in General Practice has been drafted.

These plans, within the auspices of the Pegasus Medical Group, seem to parallel

agendas being pursued by the regional health authorities, one of which is to control demand driven expenditure and lessen medical control of primary care services. The Pegasus Medical Group in Canterbury, similar to other Independent Practitioner Associations in New Zealand, was formed to ensure that medical general practitioners strengthened their position as contractors in relation to the regional health authorities.

Whatever their private anger at finding the change in administration of the practice nurse salary subsidy in process without their consultation or knowledge, the response taken by the nurses was judicious. As such, it is in keeping with the tone conjured by the term "collegiality", with its assumptions of collaborative relations between doctors and nurses. The collegial rhetoric draws on assumptions underpinned by the professionalising discourse which asserts the power of the practitioner (Witz,1994:38). Such ideas inform the occupational strategies engaged in by practice nurses, which can best be described as "softly, softly" - strategies which contribute to the gendered nature of their construction of collegial practice.

Pursuing further credentials is an occupational strategy which distances practice nurses from notions of formal "political" action, but contributes to their bid to institutionalise a distinctive knowledge base (Witz,1994:23). All the practice nurses who responded to the questionnaire indicated some interest in pursuing on-going educational opportunities, and indeed throughout the research process many of the nurses complained to me they lacked the time or money available to do this.

When the nature of the credentialism pursued by practice nurses is explored it reflects some of the contradictions of their locations in general practice. Most practice nurses want to provide "holistic" care for their patients in terms of promoting health and well-being through education. However, the nature of the tasks on the worksheets, prepared by the liaison committee of the Pegasus Medical Group, tend to exemplify what Anne Witz describes as a dependent

"extended role" (1994:31) for nurses. Nurses' "extended role" entails enhancing their sphere of competence by the incorporation of specialist medically derived and approved tasks. The tasks include First Aid management of minor injuries; emergency procedures for example Cardiac Pulmonary Resuscitation; ear syringing and assessment; venepuncture; interpreting and recording laboratory results; immunisations; diabetes monitoring; treatment of warts with liquid nitrogen; blood pressure monitoring; management of asthma; wound care and preparation and assistance with minor surgery (Pegasus Medical Group,1995), tasks which tend to need medical jurisdiction such as prescriptions for pharmaceuticals for treatment to be complete. This reflects the reality of practice nursing as an occupation operating within sets of power relations that have been shaped as much by patterns of dominance and subordination as they have been by bodies of nursing knowledge (Witz,1994:37).

The "extended role" is in contrast to what Witz (1994) identifies as a potentially independent "enhanced role" where nurses combine "carative" skills with strategies which involve seeing patients as partners rather than receivers of care. The degree to which practice nurses can function with an "enhanced role" is currently dependent on the nurses' relationships with the general practitioners who employ them. Throughout the research process the concept of patient as "partner" was rarely used. More often, practice nurses spoke of themselves as an advocate for, rather than in partnership with, patients or those using the services of general practice. They consciously positioned themselves between the general practitioner and the patient/client, recognising, as indicated by their claims of association with medicine, that their occupation of this space depends on the specific context of general practice.

The project of intensifying practice nursing as a nursing specialty demands attention to education and the acquisition and validation of special skills. The practice nurses involved in Canterbury have launched their own educational initiative rather than use existing nursing models. Despite the Christchurch Polytechnic offering a course in practice nursing as part of their on-going

educational programme, in 1988 a practice nurse initiated course was set up as part of the Postgraduate programme of the Christchurch School of Medicine. The present Tutor of Continuing Education at Polytechnic spoke to me of the nursing perspective she perceived her course presented in contrast to the medical model she understood was emphasised through the postgraduate practice nursing programme, where the Postgraduate Tutor of Practice Nursing works alongside the Postgraduate Tutor in General Practice. From the perspective of the Polytechnic the postgraduate programme is not seen as a nursing resource.

The Polytechnic course appears useful as entry training for a position as practice nurse, in contrast to the postgraduate programme which emphasises on-going education of specific interest to nurses, and also doctors, working in general practice. The present postgraduate tutor works with the practice nurses involved in the nurses' professional organisation, the New Zealand Nurses' Organisation, whose national division has been instrumental in establishing a National Practice Nurse Diploma which can be taken by distance learning modules from the Open Polytechnic. Practice nurses had approached the New Zealand Nurses' Organisation professional nursing advisor to ask for an accreditation or credentialling system where the mastering of a body of knowledge and acquired skills in a nursing specialty are formally recognised (Trim,1995:11). This is different from accreditation of educational programmes by the New Zealand Qualifications Authority since it involves recognition of a body of knowledge acquired through experience within a nursing specialty, in this instance within the context of general practice.

5.6 Conclusion

Walby and Greenwell (1994:58) argue that the notion of successful teamwork in primary health care assumes both hierarchal aspects and symbiotic interdependence, based on discrete areas of expertise. The practice nurses who participated in this study are strategically utilising these assumptions to renegotiate their place in the primary health care team. Most practice nurses want to pursue a closer association with medicine in the sense of the

"nurse/doctor team" within general practice, rather than be grouped with other community nurses as a nurse/nurse team. Only **19%** of the practice nurses who responded to the questionnaire indicated that they would be interested in extending the scope of their practice to independent **nursing** practice. Instead, through an inclusive rhetoric of collegiality, most practice nurses are moving towards a practice based on relations of symbiotic interdependence with general practitioners, utilising notions of "teamwork" to cut across traditional divisions of curing and caring. Some practice nurses are constructing general medical practice as the "ideal" nexus from which to deliver primary health care services.

The politics of the Pegasus Medical Group may have unwittingly provided the best circumstances for the development of "collegial" practice. The contract between members of the Pegasus Medical Group and the Southern Regional Health Authority which defines general practitioners **and** practice nurses as "subcontractors" (1993:3), appears to give members of the Pegasus Medical Group tighter control over both the services they collectively expect the nurses to provide, and the general practitioners who employ practice nurses. This works in favour of the pursuit of accountability by regional health authorities as it provides a peer system for monitoring of the practice nurse salary subsidy.

Practice nursing as a nursing specialty is being defined in a variety of different ways. Nurses are looking to their association with medicine to legitimate such a specialty, while at the same time the assessment of their nursing practice demands the construction of hierarchies within practice nursing. This is being accomplished in the context of new nursing philosophies which emphasise the holistic, people-centred, carative nature of nursing as an alternative to the scientific, technologically related, curative discourses associated with medicine. Apart from the murmurs of disapproval from the Christchurch Polytechnic, the idea seems to be gaining credibility from most practice nurses.

In some respects practice nurses conform to Witz's model of functionally flexible nurse practitioners (1994:41), whose relationship with the patient is informed

more by a rhetoric of customer satisfaction than by a philosophy of patient advocacy and partnership. I have argued in Chapter Four that practice nurses contribute to customer satisfaction and the businesses of general practice, in the sense of providing co-ordinated continuity of care, sometimes for entire families. In other respects, they diverge from this model in the construction of themselves as "collegial practitioners". The case of the practice nurses who are the focus of this inquiry seems different from the analysis offered by Witz (1994) where the focus is on occupational struggles against a dominant medical profession. It may be more useful to see practice nurses as teamworkers, co-ordinators, and communicators, situated at the centre of the primary care web. Practice nurses strategically utilise a variety of resources - including the discourse of teamwork - as they live the contradictions of collegiality with general practitioners, while also occupying the position of employees.

CHAPTER SIX

MORE THAN MEETS THE EYE: VISIBILITY, PARTNERSHIP AND GENDER

More than meets the eye was the phrase chosen by the National Practice Nurse Division[1] to accompany a logo representing a stylized practice nurse[2]. This smiling stick figure was available in badge form for practice nurses at the 1994 National Practice Nurse Conference. As both researcher and former nurse I was interested in the political overtones of the phrase *more than meets the eye.* The claim that practice nursing be noticed challenges the invisibility of nursing practice, and was in tension with my own socialisation as a nurse. When I worked in hospitals nurses were expected to accept this invisibility and facilitate the often heroic and more significant interventions of doctors. As Carpenter (1993) indicates, being a good nurse is being invisible:

> A good nurse traditionally is one who is not noticed, but quietly and in a self-effacing way goes about her allotted tasks (Carpenter,1993:95).

This study has attempted to make practice nursing visible. I have also argued that the complexity involved in practice nursing is not adequately captured by descriptions of nurses as "subordinate". Some years ago my curiosity in this research was sparked by a comment about practice nurses which suggested that some nurses were "apathetic" about pursuing their autonomy, by neglecting to enter into disputes about their rights to do certain forms of work. The notion

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[1] For example, it was used by the National Practice Nurse Division, New Zealand Nurses' Organisation, as part of the heading in their *Submission on the Report of the Taskforce on Strategic Planning for the Future of General Medical Practice* (1994).

[2] See Appendix F for a copy of the logo.

of practice nurses as "apathetic" was inconsistent with my experience of practice nurses as efficient and authoritative health care workers, utilising and extending the skills gained through training as nurses in hospitals, crucial health care workers in the current context of health care reform and an increasing emphasis on health promotion and illness prevention. Like the phrase *more than meets the eye*, such inconsistencies hinted at a complexity beyond superficial understandings of practice nurses as "structurally caught" (Wicks,1995:123) in subordinate positionings in relation to general practitioners and state managers of health. This study indicates that practice nurses are active agents renegotiating relations between themselves and general practitioners.

The focus of my analysis has therefore not been on the subordination of practice nurses but the skilful way in which they are involved in occupational strategies which aim to redefine "teamwork", and construct themselves as partners rather than subordinate professionals in the delivery of primary health care through general practices. Although avoidance of overt political action by some practice nurses makes it difficult for these nurses to construct a collective identity, practice nurses are positioned in significant ways in the delivery of primary care services. Within individual workplaces practice nurses and general practitioners tend to be involved in complementary work. While the commitment to "meet everyone's needs" may disrupt the construction of a "fixed" professional identity, it allows practice nurses to utilise the discursive resource of "teamwork" to work across rigid professional boundaries. This contributes to the possibility of constructing themselves as "collegial" practitioners, worthy of an inclusive "nurse/doctor team" relationship.

In this respect, the professionalising strategies of practice nurses are both similar to, and different, from the analyses of nursing offered by both Witz (1994), and Abbott (1988). Witz describes two ways in which British nurses are enhancing their roles. Some practice nurses are reclaiming primary care areas of competence, such as immunisation, as their "specialty" areas, an aspect of what Witz has termed as an "enhanced nursing role" (1994:31). Witz suggests that

this role has the potential to create a sphere of autonomous nursing practice, most particularly in primary care activities (1994:31). This study suggests that many practice nurses in Canterbury utilise aspects of what Witz terms an "extended, curative role" (1994:31). Practice nurses perform medically derived tasks such as wound suturing, and make preliminary diagnoses and give treatment according to protocols approved by their employing doctor/s. Such a path may be seen as capitalising on "doctors' pragmatic concerns with escalating workloads and excessive routinisation of some medical procedures" (Witz,1994:31).

The practice nurses in this study are renegotiating a practice based on relations of symbiotic interdependence with general practitioners, rather than an autonomous nursing role independent of medical doctors. While the nurses are pursuing recognition of their work in "specialty areas", they also enjoy performing the medically derived tasks which are available to them through the context of general practice. They see such tasks as part of their professional work as practice nurses, and as complementary to the work performed by medical doctors. Witz acknowledges that the "extended curative role" and the "enhanced carative role" are not mutually exclusive (1994:31). This study suggests that practice nurses skilfully combine both "paths". For this reason, it may be more useful to see practice nurses as teamworkers, co-ordinators, and communicators, situated in general practice at the centre of the primary care web, rather than being constrained in specific nursing roles.

Some practice nurses are engaging in occupational strategies centred around the discursive notion of an **inclusive** "professional team". This is a different development from Abbott's (1988) conceptualisation of the nursing profession as occupying a "limited settlement" (1988:74) in relation to the exclusive, dominant medical profession. For Abbott, each profession is bound to a set of tasks by ties of jurisdiction, the strengths and weaknesses of these ties being established in the processes of actual professional work (Abbott,1988:33). Rather than making specific jurisdictional claims, some practice nurses are

working across hierarchal professional boundaries through complementary work with doctors. Complementary work recombines sets of tasks from both medical and nursing professional practice. This is not to deny the existence of hierarchal relations between doctors and nurses, nor the crafting of situationally specific spheres of competence, but the focus of the practice nurses who participated in this study is on the construction of symbiotic relations between doctors and nurses who are working together to deliver an inclusive "expert service". This focus contributes to the construction of general practice as the ideal nexus of primary health care delivered by the professional complementary "team" of general practitioner/s and practice nurse/s.

Occupational strategies engaged in by some practice nurses are reminiscent of those pursued by advocates of "family" medicine as a "specialist" practice. General practitioners also work across boundaries as medical "generalists". They work in various fields of medicine. The discursive use of "teamwork" is utilised by general practitioners to promote general practice as a "support" (Wright-St Clair,1989:xii) for specialist practices. A general practitioner will seek "specialist and other consultation when he (sic) feels this is appropriate" (Richards, in Wright-St Clair,1989:81)[3]. In this way, general practitioners act as the connection between medical specialists and patients in the same way as practice nurses often act as the connection between general practitioners and patients.

The establishment of the position of postgraduate tutor for practice nurses in Canterbury, the interest in establishment of a Practice Nurse Quality Assurance Facilitator, and the proposed system of accreditation for practice nursing, are credentialist initiatives which are similar to those taken by general practitioners to establish general practice as a specialty. Vocational training programmes for general practice began slowly in the 1950s with one-year training registrarships, and by 1977 a national co-ordinator of the Family Medicine Training Programme

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[3] This quote is taken from the section on "Teamwork" which appears in the Charter for General Practice, which was drawn up and refined by Associate Professor John Richards in 1975 (Wright-St Clair,1989:80).

was appointed by the then Minister of Health, Frank Gill (Wright-St Clair,1989:91). Mr Gill has been quoted as seeing this appointment:

> as an essential first step towards the time when general practice, or family medicine, becomes a specialty in its own right (in Wright-St Clair,1989:93).

Both general practitioners and practice nurses utilise peer scrutiny to maintain standards of practice. The Royal New Zealand College of General Practitioners, established in 1974, became the accrediting body for approving the hospital experience of general practitioners who wished to become members of the College (Wright-St Clair,1989:82). Aspiring practice nurses applying for jobs with members of the Pegasus Medical Group may in future have their practice assessed by "an experienced practice nurse" (Pegasus Medical Group,1995). In Christchurch, there is interest in the establishment of a practice nurse co-ordinator whose proposed role is indicated by Anne Manchester, co-editor of *Kai Tiaki: Nursing New Zealand* as:

> to ensure uniformity of nursing standards, to oversee the subsidy, and assist in the orientation of new nurses (Manchester,1995:14).

Witz utilises aspects of the post-Fordism flexibility debate to help understand developments in nursing (1994:40). Her description of a functionally flexible nurse practitioner is one:

> ... whose relationship with the patient is informed more by a rhetoric of customer satisfaction than by a philosophy of patient advocacy and partnership (1994:41).

Their partnership with doctors as health professionals was the preoccupation of most of the practice nurses who participated in this study, rather than a philosophy of "patient partnership". At the same time, practice nurses express strong philosophies of patient advocacy. It shapes the complex nature of the "care" they deliver to patients/clients in general practice. Practice nurses are constructed as those who often determine that the "care" patient/clients receive is "very good" even if as a result of delivering "quality care" the practice's profits

are diminished. Practice nurses feel entitled to utilise discursive notions of discretion over fees-for-service because 63% of their salaries are funded by the regional health authorities. At another level, utilising discretion over fees often works as a public relations exercise, influencing the patient/client and their families to return time and again to the practice. In this way, effective public relations by practice nurses facilitates surveillance and normalisation of people/clients who attend the practice, in accordance with the aims of the provision of the practice nurse salary subsidy through the regional health authorities whose vision is for better preventive and primary health care (Southern Regional Health Authority,1994:3).

The way many practice nurses combine "partnership" with doctors and "care" of patients/clients obscures the financial significance of their work for the individual businesses in which they are employed. Caring "for" and "about" both patients and employers tends to construct practice nurses as voluntary and gendered carers, rather than "professional" health care workers. This is reflected in the allocation of physical space for practice nurses within the general practices in which they are employed. Some practice nurses engage in extra "housekeeping" such as cutting disposable pads in half, to diminish practice expenditure. Most nurses ensure patients/clients flow easily from the waiting room to the general practitioner's room, often "screening" to see if they could save the doctor time by taking blood pressures or performing pregnancy tests, acting as "gatekeepers for the gatekeepers". Practice nurses are involved in time consuming organizational work which ensures the smooth operation of the general practices in which they are based. At the same time, practice nurses who participated in this study make key commercial decisions with respect to medical supplies.

As I observed a practice nurse during fieldwork in an inner city practice interrupt her nursing tasks to attend to telephone calls from methadone users desperate for repeat prescriptions, to order supplies from a visiting medical supplies salesperson, to find misplaced results for the receptionist and

consequently soothe a patient/client, and to confer with the doctor over a dressing for a severely burnt hand, I likened her work to "the glue that holds the practice together". Her "service" work was crucial to maintain the daily workings of the general practice as a small business. Like negligible traces of glue, practice nurses face challenges in specifying that their work is *more than meets the eye.* The "care" given by practice nurses includes caring "for" the doctors as well as the patients/clients. As such it is a vital component of the interdependence of social relations and discursive notions of "collegiality" and "teamwork" utilised by many practice nurses.

Their position as employees allows most practice nurses to blur rigid professional boundaries since any challenge to jurisdictional claims is controlled by their employing doctors. Nevertheless, the definition of general practitioners and practice nurses as "subcontractors", in the contract between members of the Pegasus Medical Group and the Southern Regional Health Authority (1993), infers that practice nurses are independent professional workers. The language of this contract suggests that practice nurses are able to negotiate contracts to provide practice nursing services, with either the Pegasus Medical Group, or the Southern Regional Health Authority. To date, the only contracts practice nurses have entered into are contracts of employment with general practitioners.

Practice nurses still face difficulties in specifying what their work is worth to the general practices who employ them as primary care workers. The pilot bulk funding arrangement currently being pursued by both the Pegasus Medical Group and the Southern Regional Health Authority, which includes the administration of the practice nurse salary subsidy, provides a peer system of accountability for monitoring this subsidy. The subsidy is currently used by some general practitioners to finance a variety of different forms of work. A system whereby doctors monitor other doctors' use of public funding is useful for managers of public funding for primary health care, but does little to improve the visibility of the key role played by practice nurses in the relationship between general practitioners and the regional health authorities.

Witz (1994) has observed that gender is a crucial factor in understanding the occupation of nursing. Although the relationships of work in general practice are often highly gendered, this is not always a source of constraint. The gender of practice nurses is an advantage in practices where the doctor is a male, as the nurse can provide services sought by women who prefer female health care workers, and in this way contribute significantly to the business of the practice. Paradoxically, practice nurses may have less opportunities to engage in tasks usually assigned to doctors, if they are employed by female general practitioners. As the doctor can charge a higher fee-for-service, and claim the General Medical Subsidy, tasks like cervical smears, which could be done either by a doctor or a nurse, may be performed by the female general practitioner as they can charge a higher fee, and the General Medical Subsidy, for their services.

The trend for general practice to attract female doctors may diminish the opportunities for practice nurses to do some of the professional work which many find more satisfying. The trend to structure general practice hours along the lines of "business" hours, with the establishment of co-operative "After Hours" facilities, has made general practice even more accessible to female doctors who are often more likely to have to balance career and domestic responsibilities. While the practice nurses who participated in this study spoke warmly of working relationships with some female general practitioners, some nurses were critical of the tendency for female doctors to insist on performing **all** the cervical smears, and to utilise generous amounts of physical space to do so. Gender therefore matters in general practice in ways that are far more complex than a simplistic traditional male doctor/female nurse division of labour. Space, time, gender and economics are woven together in complex ways in the organisation of primary health care.

My focus in this thesis has been on practice nurses. Arising out of this focus is a need for more detailed attention to the relations among different sets of actors associated with the delivery of primary health care. These include relations between managers of general practices who may be either general practitioners

or practice managers, and managers of publicly funded health care services. It also includes relations between managers of pharmaceutical companies, managers of laboratories, and those who manage individual businesses of general practice. What do general practitioners mean when they argue that nursing services should become "truly community based" (Turnbull,1996:12)? This study indicates that "connecting with the community" may be consistent with the focus on "service" which is also essential in sustaining small businesses - both are facilitated through the work of practice nurses.

Future challenges for practice nurses include the creation of effective, interdependent relationships with other community nursing groups, as well as the forms of partnership currently being developed with general practitioners. Other challenges facing practice nurses involve their relationships with practice managers who are being appointed in increasing numbers. Managers do not usually share the obligations to balance cost and care which have been articulated by many of the practice nurses who participated in this study. *More then meets the eye* hints at the difficulties practice nurses face as they live the contradictions of collegiality while also occupying positions of employees. Nevertheless, aspects of the nurses' work assumed to be gendered, such as connectedness and communication, are clearly defined in a general practice nursing service as forms of professional work. This professional work is particularly beneficial to both the businesses of general practice and the management of publicly funded primary health care.

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APPENDIX "A"

THE PRACTICE NURSE PROJECT

A DISCUSSION DOCUMENT PREPARED FOR

THE CANTERBURY PRACTICE NURSE SECTION

BELINDA MORTLOCK

REVISED AUGUST 1993.

ABSTRACT:

This project aims to explore the situation of practice nurses in the context of planned changes in the organisation and delivery of primary health care. It will be written as an M.A. Thesis to be completed over two years at the University of Canterbury. The research will examine the variety of contributions practice nurses make to general practice. It will explore the ways in which practice nurses may extend their skills and degree of autonomy on the job. Possible options for future delivery of practice nursing services will be examined, and attempts made to monitor any changes that are occurring. The design of the research will be flexible, and with the permission of the Canterbury Practice Nurse Divisional Committee, will consist of a combination of methods. The intention is to begin with a survey of practice nurses in the Canterbury area, and then engage in some participant observation in general practices. After the survey has been analysed, it will be complemented by indepth interviews with 10 of the practice nurses who responded to the survey.

DISCUSSION:

Setting the context:

Practice nurses are employed by general medical practitioners and work within general medical practices. The State provides general practitioners with a subsidy of $11.00 an hour, 75% of the current hourly rate, to provide a practice nursing service. Included in the objectives of the Practice Nurse Salary Subsidy Scheme are the expectations that the provision of practice nurses will

> improve the range, quality and accessibility of primary health care services and encourage health promotion, education, disease prevention and health maintenance (Health Benefits Letter No 2).

The fact that practice nurses are employed by another party, the general practitioner/s, means that what constitutes a practice nursing service differs according to the employing general practitioner/s. The extent to which practice nurses are able to meet these expectations varies. Although the provision of Standards for Practice Nurses (1990) states

> nurses work as independent and interdependent members of the health care team (ibid:26),

their independence as health professionals is limited by their status as employees of general practitioner/s.

The former Minister of Health (Simon Upton) has signalled the end of the Salary Subsidy Scheme as part of the proposed health reforms. Although the RHAs have continued the subsidy for another year, it seems only a question of time before practice nurses have to reorganise the way they are employed. Likely forms of future employment are through contracts with general practitioners or, for some nurses, self employment as independent nurse practitioners. Simon Upton also suggested the

> removal of traditional constraints to autonomous practice to extend nurses' role in both their own interests and those of the community (Upton, 1991:65).

Although he was unspecific as to what constraints would be removed, and has now been replaced by Mr Birch as Minister of Health, it is clear that there will be some change in the delivery of primary health care services.

The suggestion that some nurses go into private practice has been viewed with caution by many practice nurses. General practitioners rarely embrace the concept of independent nurse practitioners, preferring instead to talk about "the health care team of health co-professionals" (Turnbull, NZMJ 1991,104:519; The Press 22.3.1993). Independent nurse practitioners operating in a clinical medical model in Christchurch find they are severely constrained, not only by legal restrictions on the processing of Community Services Cards but also by the "gatekeeping practices" of general practitioners. Clients cannot claim medical insurance nor Accident Compensation for services from a nurse, so the nurses' client base is further restricted.

Some nurses fear the nature of the health reforms will involve an attempt to set them up as "cheap and not very good doctors" (Acker, NZNJ 1992:22). They have argued that their value lies in the difference between nursing and medicine and say they do not want to be tied to "the narrow scientific model of diagnosis and cure" (Acker,ibid). New Zealand nurses as a group are anxious to increase their status as professionals. They have moved from hospital-based to polytechnic-based training and are arguing for increased educational

qualifications (Vision 2000 Committee Discussion Paper,1992). Current literature emphasises the technical, intellectual, skilled nature of the contemporary nurse (Turner,1981; Benner,1984; Christensen,1990). This provides an alternative to the public perception and stereotype of nurses as the altruistic handmaidens they were once expected to be. The "technical, skilled" nature of nursing is usually seen in conjunction with the sophisticated technology found in modern hospitals. There is little technology in general practice. The variety of skills used, the similarities and differences in the work experiences of individual practice nurses, are not readily apparent.

Findings from a small pilot study I carried out last year in Christchurch suggest that practice nurses are women with "life skills" possessing, for example, listening and counselling skills, although these may not be officially recognised. The pilot study comprised one indepth interview with a practice nurse, and questionnaires submitted to five other practice nurses, one who was from a rural practice. During this study it became apparent that I could not study practice nurses as an isolated group because they always operate in relationship to the general practitioner/s, and also in relation to other health professionals or clerical staff working within the practice, hence my interest in doing some observation of what happens in a number of general practices.

Practice nurses work in different circumstances from other nurses in that their workplaces are relatively isolated. There are seldom more than two or three nurses working at the same location. Their best chance of collective action is through their professional organisation. The New Zealand Nurses' Union and the New Zealand Nurses' Association have recently amalgamatedand are now known as the Nurses' Organisation. It seems timely to document individual experiences of changes occurring in both forms of employment and the services practice nurses deliver, as well as changes in the way nurses organise themselves. My interest is in how each of these changes impact on each other.

Questions arising from the context:

This context generates many questions for researchers. The following sub-headings show the main areas of inquiry, and the sorts of questions I would like the research to answer.

1. What does a practice nursing service consist of?

I do not expect there will be a single answer to this question. What I am interested in is firstly capturing the variety of contributions practice nurses make to general practice. What is common to and what is different about individual practice nursing services? Secondly, how are individual practice nurses used in general practice to promote health, and to prevent disease, as suggested by the aims of the Practice Nurse Salary Subsidy Scheme?

Do some practice nurses work beyond the walls of the general practice? Perhaps their primary health care work extends to educational seminars at schools or kindergartens for example, or they may be part of immunisation or screening promotions at shopping malls. Is what some practice nurses do shaped by factors such as the differing health needs of the clientele? There will presumably be a greater emphasis on immunisation for example, in practices with relatively large numbers of young children.

How are the nursing services described in material about the practice? The pilot study revealed that much of some nurses' time is still taken up with reception and office duties. How much time is taken up with reception work as opposed to what would conventionally be defined as nursing duties? This raises the question of to what extent are practice nurses actually nursing?

2. Documentation of variety of skills:

What nursing tasks are practice nurses doing? To what extent are these shaped by the demands of the employing general practitioner/s, their attitudes, or their special interests? If a nurse works with two or more general practitioners how does she accommodate their differing demands? One of the nurses taking part

in the pilot study mentioned she loved suturing but because that was also a special interest of the general practitioner she rarely had the opportunity to practise this skill.

All the practice nurses in the pilot study said they would like to extend their skills and widen the scope of their work. To what extent are individual practice nurses able to extend their nursing skills, to specialise in certain areas? Who would pay for them to do this? In what directions would they be able to widen the scope of their work while still within the parameters of general practice? Some of the nurses in the pilot study said they would like to include domiciliary visits in their jobs, others would like to be involved in more social work.

Do most practice nurses organise their paid employment around child care and voluntary activities? Are most practice nurses more likely to be hospital-trained rather than polytechnic-trained? Do some practice nurses possess "life skills", such as management of time and efficient utilisation of resources? An examination of how these skills are utilised in the general practice setting would be useful. To what extent do practice nurses consider dealing with people's emotions a natural and "invisible" part of their job as nurses?

3. Degree of autonomy on the job:

This section would look at the extent at which practice nurses could work at a level which could be described as "autonomous". This would include looking at constraints that some practice nurses may feel. For example who decides what work the practice nurse carries out each day? Do some practice nurses have their own working space? Do they have responsibility for certain clients who need nursing care? It would be interesting to know if clients ask for care from the practice nurse.

The degree of autonomy enjoyed by practice nurses will be shaped by other factors, for example the location of the medical practice. Does the nurse attached to a rural practice have more individual responsibility due to distances

which need to be covered and the resulting inaccessibility of the medical practitioner? If the practice nurse runs educational programmes, who decides the content of these? Does she work in consultation with the general practitioner/s?

The "team" concept is often referred to. Do some practice nurses see themselves working in a team of health co-professionals? What do practice nurses understand by the term "collegial practice"? Doreen Hounsell has called for a "collegial relationship" between practice nurses and general practitioners (NZPNJDec,Dec1992:40). How do practice nurses view their relationships with their employing general practitioner/s? These questions may depend on other factors such as the length of time the practice nurse and general practitioner have been working together, and whether or not the nurse works full or part-time.

4. Readiness for change

How ready are practice nurses as a group for change? It will be useful to know the degree of consultation practice nurses have had with their general practitioner/s about the proposed changes. For example how many know if they have been included in their general practitioners' preliminary contracts to the RHAs for funding? Not all general practitioners want to contract to the RHAs, some are willing to forego subsidies altogether to avoid contracting (New Zealand Doctor 18 March 1993:5). The RHAs have confirmed they will roll over the existing practice nurse subsidy for another year. What will happen after this?

What sort of networks do practice nurses as a group operate? Now their professional organisations have amalgamated, what can they expect in the way of help? If their services are to be contracted to general practitioners they will presumably need advice on the best way to achieve a fair and equitable contract. How will they organise themselves to achieve this?

5. The Question of Independent Practice:

What are the levels of interest in independent practice? This will presumably

depend on what specific "traditional constraints" against independent nursing practice are removed, and what resources are provided. From where could they expect funding? The granting of limited prescribing rights to nurses has been suggested. How would general practitioners respond to this? What sort of opposition could practice nurses expect?

Methodology:

My approach to the research will be mainly qualitative and informed by feminist theory and research practice. Feminist researchers have a commitment to research which is primarily for women, and to research which focuses on the experiences of women. Because women's voices are often diminished in, or excluded from, certain arenas (Du Plessis,1993:6) I will focus on the in-depth interviews as a means of documenting what practice nurses have to say about their work experiences. Feminist researchers see social research as a social process - one which demands a self-consciousness and self-criticism on the part of the researcher (ibid:8). In this instance such a process would include my establishing a continuous dialogue with practice nurses, seeking and taking advice, and feeding back information and analysis. These strategies are designed to increase the control of, and ultimately empower, those who participate in the research.

The research design:

This research will be used as the basis of an M.A. Thesis, to be completed in the Department of Sociology at the University of Canterbury over two years. The research design must be flexible. The specifics of the proposed changes to health service delivery are still uncertain yet there seems no doubt there will be some re-organisation of the delivery of primary health care. What positions are created and how practice nurses fit into these, will be one focus of the project. However the primary focus will be the diverse nature of practice nursing, and the issue of the contributions practice nurses make to the area of general practice, and to

primary health care in general. To enable the project to proceed I have negotiated with and obtained the informed consent of the Canterbury Practice Divisional Committee.

With their consent I would like to begin with an approach of two parts: firstly, I have decided to survey all practice nurses in the Canterbury area. This will be done shortly through a postal questionnaire. It would be useful for socio-demographic data, and to test basic assumptions, for example that most practice nurses are in the age bracket 35-45 years and received hospital-based training. The questionnaire has been pre-tested for ambiguity and irrelevance. From the replies I would choose 10 nurses whom I would ask to talk to me in more depth about their work and the issues which currently confront practice nurses. I hope to tape record these conversations. Participation in the survey and interviews would, of course, be entirely voluntary.

The second part of the study will be some participant observation in general practices. How much time is spent, and how many practices, will depend on negotiation with selected practice nurses, and their employing general practitioner/s. This will involve negotiation and consent from the Christchurch branch of RNZCGPs. This phase of the research is also dependent on discussion with the Practice Nurse Divisional Committee. I expect this participant observation to sharpen up aspects of the project and provide information relating to areas of significance other than the health sector reforms. Interviews with general practitioners could be a useful way to understand the context in which practice nurses presently work.

If the health reforms do proceed and there is significant change in the delivery of primary health care I would like to survey practice nurses again next year to see how their circumstances have changed. I should also like to do further interviews. I am very conscious for the need for confidentiality, and am aware that what people say in an interview can be misquoted or misinterpreted. The transcripts of all the tapes will be returned to the individual nurses interviewed

for perusal and comment before they are used as research material. If requested, the audio tapes will be returned to the participants in the study. As much as possible I want to use the nurses' own words in the thesis.

Ethical concerns:

I am a registered general nurse with a current practising certificate although I have not practised for eighteen years. I am attaching a curriculum vitae to show my academic qualifications. I am aware that research of this nature is sensitive, and of the need for complete confidentiality. All names will be changed and information altered so nurses and general practitioners who participated will not be recognisable. Any information about clients which might be obtained during a period of participant observation will also be treated as confidential. The participant observation I would like to do as a component of the project will also depend on the consent of the general practitioners concerned, who will also receive a copy of this document.

I welcome the participation of the Divisional Committee in this research. I think we would both benefit from a co-operative relationship, and I would be happy to discuss any part of the research. I would send you a copy of the finished thesis for your records, and would be happy to contribute material about the research to journals and newsletters read by practice nurses.

SUPERVISORS OF THE PROJECT TO BE WRITTEN AS AN M.A. THESIS:

Ms Rosemary Du Plessis,
Senior Lecturer,
Department of Sociology,
University of Canterbury,
Private Bag,
Christchurch.

Telephone (03) 3667001 ext 6878

Dr Terry Austrin,
Senior Lecturer,
Department of Sociology,
University of Canterbury,
Private Bag,
Christchurch.

Telephone (03) 3667001 ext 6980

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APPENDIX "B"

Canterbury Practice Nurse Division

Division of N.Z.N.O.

8 July 1993

14 Mascot Place
Christchurch 6.

Dear Belinda

I apologise for my tardiness in not writing sooner to confirm to you that the Canterbury Practice Nurse Division are happy to give you approval for your research into Practice Nursing. We are very excited by your proposal and are willing to help in anyway we can. We have established a sub-committee to work with you as needed in advisory etc capacity.
The members of this sub-committee are:-

Colleen O'Connell
14 Mascot Place
Christchurch 6
3853991 (H) 3891176 (W)

Alison Harrington
101 Santa Maria Ave
Christchurch 8
3844092 (H) 3892550 (W)

Lynne Gibbons
44 Mays Road
Christchurch 5
3554739 (H) 3663391 (W)

Elizabeth McKenzie
8 Coleman Ave
Christchurch
3483672 (H) 3663257 (W)

We look forward to a fruitful and rewarding 2 years working with you on this important research.

Yours sincerely

Colleen O'Connell
Chairperson
Canterbury Practice Nurse Division
NZNO

APPENDIX "C"

QUESTIONNAIRE FOR PRACTICE NURSES

Please tick the appropriate box(es), or write your response in the space provided.

1. Which ONE of the following BEST describes the practice from which you work?

   [ ] an inner-city practice
   [ ] a suburban practice
   [ ] a rural practice

2. Which ONE of the following BEST describes the composition of the client base you and your doctor/s work with?

   [ ] all age groups
   [ ] predominantly families with younger children
   [ ] more elderly patients than any other group
   [ ] specialist practice with appropriate age group
   [ ] other, please describe

   _____

3. How many General Practitioners do you work with?

   [ ] 1 in a sole practice
   [ ] 1 in a group practice
   [ ] 2 in a group practice
   [ ] more than 2 in a group practice

4. Do you work full or part-time as a practice nurse?

   [ ] full time (30 - 40 hours)
   [ ] part time
   [ ] job share

5. How many hours on average do you work each week? eg. [8]

   [ ]

6. Does the practice employ other nurses?

   [ ] no
   [ ] yes, if YES how many other nurses are employed?
   [ ]

7. What sex is/are your employing general practitioner(s)?
   Please write the number of each sex eg. [2] female

   [ ] male
   [ ] female

8. Who decides what work you do each day?

[ ] the General Practitioner(s)
[ ] yourself in consultation with the General Practitioner(s)
[ ] yourself in consultation with the team of health professionals working at your practice
[ ] you do.

9. Do you have your own area, other than the treatment room, to work from? eg. a separate room or a desk

[ ] no
[ ] you have a designated area but share it with health professionals other than practice nurses
[ ] yes

10. Is your practice computerised?

[ ] yes
[ ] no

if YES, how is it used? eg. recall, appointments, medication, morbidity/mortality, auditing.

_____

_____

_____

11. To what degree are you part of the general practice management decision making process?

[ ] to a limited degree
[ ] to a considerable degree
[ ] not at all

12a) Using the column marked "A", please mark the aspects of your work you think are

1 = very important;
2 = moderately important;
3 = not important

12b) Using the column marked "B", please mark what you actually spend most of your time at work doing by using the following

1 = a lot of time
2 = some time
3 = do very little

"A"	"B"	
[ ]	[ ]	organising the practice so things run smoothly
[ ]	[ ]	listening to patients, providing support, reassurance, and counselling
[ ]	[ ]	preventive screening procedures (recall systems, blood pressure checks, cervical smear taking etc)
[ ]	[ ]	reception and clerical work (filing, making appointments)
[ ]	[ ]	being able to identify common minor illnesses and give appropriate advice
[ ]	[ ]	teaching about health maintenance (giving up smoking, importance of exercise and diet, when to call the doctor etc)
[ ]	[ ]	practical tasks (dressing ulcers, syringing ears, giving injections, maintaining equipment)
[ ]	[ ]	advising patients about coping with illness especially chronic conditions
[ ]	[ ]	providing a liaison between the patient and the general practitioner, and other health professionals
[ ]	[ ]	telephone consultations
[ ]	[ ]	other, please specify

_____

13. Is there an area, or areas, you specialise in? eg. asthma, cervical smear taking, grief counselling?

[ ] yes
[ ] no

if YES, can you describe the area/s?

_____

Do clients ask for your services directly?

[ ] yes
[ ] no

5. Would you be interested in doing more work in any of the following areas? Tick the fields in which you would like to extend your scope of work.

[ ] social work - counselling, following-up patients, co-ordinating treatments
[ ] domiciliary nursing - doing home visits to provide nursing care and treatment
[ ] independent nursing practice
[ ] education: teaching health maintenance, preventive medicine
[ ] holistic health - eg. massage, naturopathy.
[ ] medical and diagnostic area
[ ] other, please specify:

_____

6. If you have indicated you would be interested in extending your scope of work which of the following factors prevent you from doing so? Tick box/es where appropriate.

[ ] lack of confidence
[ ] lack of your own space from which to work
[ ] lack of support from employing general practitioner
[ ] lack of competency based educative opportunities
[ ] lack of time due to nature of the present job
[ ] lack of peer support
[ ] legal constraints eg.unable to prescribe drugs
[ ] financial constraints
[ ] other, please specify

_____

17. Do you work with other nurses in your community?

[ ] no
[ ] yes

If YES, in what ways do you work together?

_____

_____

18. Do you have regular contact with other practice nurses?

[ ] no
[ ] yes

if YES, what form does this contact take?

_____

_____

19. How long have you been Practice nursing?

[ ] less than one year
[ ] 1 - 2 years
[ ] 3 - 10 years
[ ] 11 - 20 years
[ ] more than 20 years

20. Which age bracket are you in?

[ ] 25 - 29 years
[ ] 30 - 39 years
[ ] 40 - 49 years
[ ] 50 - 59 years
[ ] over 60 years

21. Are you male or female?

[ ] female
[ ] male

22. Since you graduated as a nurse have you done any of the following? Please tick more than one option where appropriate.

[ ] caring for children in your own home
[ ] voluntary work in pre-schools and schools
[ ] voluntary work with social agencies
[ ] paid work in other areas of nursing
[ ] paid work in other occupations
[ ] further education in nursing
[ ] further education in fields other than nursing

23. What nursing qualifications do you hold?

[ ] N.Z.R.N. (General)
[ ] N.Z.R.N. (Comprehensive)

24. Do you hold any other diplomas, certificates etc? These may or may not be nursing related.

_____

_____

25. Are you involved in any of the following educational activities? Please tick where applicable.

[ ] attend polytech. courses
[ ] attend the post graduate programme
[ ] read nursing and medical journals
[ ] other, please describe

_____

_____

26. What do you like about your job? What do you find stimulating and/or satisfying about working as a practice nurse?

_____
_____
_____
_____
_____
_____
_____
_____

27. Are there any negative aspects to your job? What do you find stressful or difficult? Is there anything you would like to change?

_____
_____
_____
_____
_____
_____
_____
_____

THANK YOU FOR PARTICIPATING IN THIS SURVEY

APPENDIX "D"

PRACTICE NURSING IN CANTERBURY

A PRELIMINARY REPORT ON THE RESULTS OF A QUESTIONNAIRE DISTRIBUTED TO PRACTICE NURSES IN SEPTEMBER 1993

BELINDA MORTLOCK
DEPARTMENT OF SOCIOLOGY
UNIVERSITY OF CANTERBURY
TELEPHONE: 03-366 7001
FAX: 03-364 2977

PRACTICE NURSE QUESTIONNAIRE

At the beginning of September I posted 236 questionnaires to the practice nurses in the Canterbury area. This marked the beginning of my M.A. thesis research into practice nursing in the context of changes to the organization and funding of health care. One hundred and twenty-two completed questionnaires (52%) were returned. I consider this a good response as it was the third questionnaire the practice nurses had been asked to fill out in less than a month - the National Practice Nurse Division NZNO and the Post Graduate Tutor had both sent surveys to the practice nurses in the Canterbury area in August.

The main purpose behind the questionnaire was to provide me with a broad picture of practice nursing which I could draw upon as I proceeded into the research. The drafting and distribution of the questionnaire involved working with a sub committee of the Canterbury Practice Nurse Division who pre-tested the questionnaire and suggested questions they would like included in this survey. I found this involvement with the sub-committee helpful and enjoyable.

The questionnaire also became the medium through which the practice nurses could be informed about my research and through which I could ask for further involvement from those prepared to be interviewed later. The questionnaires themselves were anonymous. Twenty-four nurses indicated they were prepared to be contacted, either to arrange a visit to their medical practice or to organise an in-depth interview.

This is a summary of what I think are the most salient points to emerge from the responses. Not all the questions in the practice nurse questionnaire were answered. The percentages given below refer to each individual question and are calculated from the number of nurses who answered that question. I have organised the material under five headings:

1 The qualifications and experiences that practice nurses who responded to the questionnaire bring to their jobs. Eighty-six percent are registered general nurses and 14% registered comprehensive nurses. More than half of those surveyed have post graduate qualifications in nursing related areas, and most (86%) have worked in other nursing positions before working in general practice. They have also had many other experiences such as caring for children and undertaking voluntary work in the community.

2 How practice nurses who responded to the questionnaire articulate their feelings about their work, mainly through their responses to open-ended questions - their comments focus on the importance of gaining trust, of helping; and of being useful to society.

3 Some indications of working relationships with employers - there is a marked variation from expressions of satisfaction with employers and working situations, to expressions of dissatisfaction, especially with the practice nurses' access or lack of access to physical space in the practice. Feelings of frustration tend to be directed towards what the practice nurses perceive to be the nature of the job rather than towards individual employers.

4 The nature of the job. Practice nurses seem to be overwhelmingly busy - lack of time due to the nature of the job is the major constraint, noted more than any other, to extending the role or scope of the work experiences of the practice nurses. The job seems to consist of tasks which require a variety of skills.

5 The implications of these observations for my research, and some remarks about the usefulness of this survey.

1 THE QUALIFICATIONS AND EXPERIENCES PRACTICE NURSES BRING TO THEIR WORK

The profile of the nurses who replied to the questionnaire is similar in respect of qualifications and experience regardless of where they work. **All the nurses are female.** Sixty-five percent work in suburban practices, 22% in rural practices, and 13% work in inner city practices. One nurse did not specify where she worked.

Most of the nurses (86%) are registered general nurses, 14% identified as comprehensive nurses. Eighty-eight percent are aged 30 years or over. Only 1 nurse is under the age of 25, and 9% are between 25 and 30. Sixty-six percent are between 30 and 49 years. Twenty-two percent are between 50 and 59, and 2 nurses are over 60 years. In the rural areas the nurses tend to be more mature, 80% of them are 40 years and over.

Most of the nurses (86%) have worked in other nursing positions before working in general practice and to have had many other experiences such as caring for children in their own homes (66%), undertaking voluntary work for pre-schools and schools (70%), and to have had education in other fields (36%) as well as post graduate education in nursing (70%). Forty-seven percent had done paid work in other occupations, an interesting finding.

Eighty nurses answered the question which asked if they had other qualifications. They showed a wide variety of other qualifications including 3 Plunket Diplomas, 2 Teacher Certificates, a Diploma of Social Work, 5 Advanced Diplomas of Nursing, 6 Midwifery Diplomas, many counselling certificates, Cervical Smear Takers certificates, Polytechnic based courses such as Emergency Care, and certificates from organisations such as St John

Ambulance for First Aid. One nurse has a Bachelor of Music degree, another her private pilot's licence. If the nurses noted an area they specialised in, and **46%** did, such as terminal care, they tended to have completed relevant Polytechnic courses or previously worked in other fields such as in oncology departments or in a hospice. A number had done Grief Counselling courses to complement terminal care and move beyond the actual patient to encompass other family members or significant others.

Most of the nurses (**88%**) indicated interest in extending the scope of their work - this is a high proportion. Areas in which nurses expressed the most interest were domiciliary work (**59%**), education (**57%**), and the area of social work (**54%**). The rural nurses noted they were already doing some domiciliary nursing. Twenty nurses (**19%**) noted an interest in independent practice; a higher proportion of these nurses worked in inner city practices. Thirty-two percent were interested in extending into the area of holistic health, and **30%** into medical and diagnostic areas. It was interesting to note that the nurses working in rural practices were more interested in holistic health, **43%** compared to **20%** from inner city practices and **30%** in suburban practices.

When they were asked to give reasons for not extending the scope of their work, **82%** ticked lack of time due to the nature of the present job. Some comments the nurses wrote at the end included *"family responsibilities, not enough time generally"; "tiring"; "too tired"; "would like to but not enough time"*. This reason stood out as a major constraint and also as an issue of stress. Thirty-two percent noted lack of space from which to work, **31%** noted financial constraints, and **17.5%** noted legal constraints. Only **15%** indicated lack of support from employing GP as a constraint, and **13%** noted lack of confidence.

Fifty-nine percent of nurses work with other nurses in the community whereas **41%** do not at all. However when broken down into figures dependent on

location of the practice, 77% of nurses working in rural areas worked closely with other nurses in the community, compared to 27% in inner city practices. The rural based nurses also reported more regular contact with other practice nurses than nurses working in inner city. Nurses working in suburban practices also work closely with nurses in the community (65%), and 86% have regular contact with other practice nurses. Only 11 nurses who work in suburban practices work without another nurse.

Of all the practice nurses, 80% have regular contact with other practice nurses, mostly through working with them at the same practice, or through education evenings organised through the post graduate programme. Sixty-two percent noted they attend the post graduate programme, some qualified this by noting "*sometimes*" or "*when possible*". Nurses working in rural practices find this difficult:

> *The main negative aspect of a rural practice is the distance to get to ongoing educational courses - makes it expensive and time-consuming to get to things*
> (NZRGN aged between 50-59, works in the community as well as in rural practice)

> *With the withdrawal of the Health Dept study leave it is almost impossible to have ongoing education - there is no-one to take your place and you have to forgo being paid if you attend courses therefore more expertise cannot be obtained*
> (NZRGN aged between 30-39, works full time in rural group practice)

Fifty-seven percent have been practice nursing between 3 and 10 years and 22% for between 11 and 20 years. Three have been working for over 20 years. Only 3 have been working for less than one year, and 15% have been working between 1 and 2 years. Several nurses noted the convenient hours when combined with family responsibilities, especially compared to the hours necessitated by hospital nursing.

> *[I like] being able to work part-time and use my nursing skills and experience whilst bringing up my family*
> (NZRGN, 40-49 age grouping, job shares 9 hours in rural practice)

Good hours - no night duty or evenings. No working PMs. Very suitable for married life!
(NZRGN, 30-39 years, full time inner city practice)

Sixty-two (51%) nurses indicated they worked full time, and 61 (49%) noted they worked part time or job shared. There was some confusion with the term "job share", many of the nurses ticked both slots or wrote after the part time slot "job share". The nurses work a wide variety of hours, 3 nurses work over 40 hours, and one nurse works as little as 6 hours. Eighty percent work over 20 hours per week. Some practice nurses relieve for the district nurse attached to the practice, and in rural practices nurses tend to wear several hats. They can be receptionist, practice nurse, health promotion nurse or domiciliary nurse depending on the need.

2 HOW THE PRACTICE NURSES ARTICULATE THEIR FEELINGS ABOUT THEIR WORK

Most practice nurses feel their job is satisfying and rewarding, both personally in terms of the trust given them, and also in terms of their contribution to "community", and to the profession of medicine itself.

I feel it is the real nursing job, the front-line community aspect, you see results - either positive or negative but it feels as though you're contributing to medicine in a real way
(NZRGN, 40-49 yrs, works fulltime for 1 male, 1 female GP suburban practice)

I find most satisfying the trust that people have in nurses generally and will thus confide in them making meaningful contact possible in most situations in my job
(NZRGN, 40-49 years, job shares, works with sole male practitioner in suburban practice)

I really enjoy the patient contact and seeing and talking to them on a regular basis longterm and knowing <u>who</u> they are and what problems they have and assisting with these. I love the young families being born and growing up in the practice. I LOVE MY JOB
(NZRGN, 40-49 years, works fulltime in suburban practice, 10 years practice nursing)

They enjoy the opportunity of *helping* people in every sense:

> [I like] *contact at grassroots level with people of all ages, helping (hopefully) people before things get out of control, guiding or giving options for people to pursue and thereby helping themselves*
> (NZRGN, 40-49 age grouping, job shares in suburban practice, works with 1 male GP)

> *I love helping people, putting them at ease, reassuring them. I like seeing them progress from sickness to health. I enjoy using my practical nursing skills*
> (NZRGN, 30-39 age grouping, job shares 15 hours)

> *...sounds corny but helping people - really satisfying when you make a change take place*
> (NZRCN, aged 30-39, works fulltime inner city practice)

They enjoy the continuity of patients, something nurses do not experience in a hospital setting:

> *I like knowing the family as a whole* (NZRGN, 40-49 age grouping, works full time suburban practice)

> *...continuation of care of patients and families, following up from beginning to end* (NZRGN, 30-39 years, 21 hours rural practice)

There is a strong sense that a large part of the nurses' identities, of feelings of self worth and status, comes through helping patients, and their families. The role of the practice nurse appears to be a supportive one in terms of both patients (they rarely use the word "client") and doctors. They seem to be the front-line person who deals with the public including the "difficult" patients - this was reflected in some of the comments on the negative aspects of the job:

> *[I dislike] the phone - bombarded with absolute dipsticks, in inner-city we get a lot of "subbies" - the real low life types which can be very demanding and difficult to handle*
> (NZRGN, 30-39 years, full time inner-city practice)

> *I find angry patients stressful when they feel they haven't got their "moneys worth" or complain about Doctor's fees*
> (NZRGN, 30-39 years, part time inner-city practice)

Stupid questions. People not taking responsibility for their own lives/health. Some days it's more like a social work convention. We're a real lifeline to some ignorant/stupid lowlifes in the community
(NZRGN, 25-29 years, full time suburban practice)

3 WORKING RELATIONSHIPS

The working relationship with the doctors who employ the nurses is obviously an important one. Unfortunately the question about the sex of their employing GP/s was misunderstood as most of the nurses gave the sexes of all the doctors in the practice not, as was meant, the sex of the doctor/s with whom they worked. Few of the nurses expressed personal dissatisfaction with individual doctors, none of those who did worked in rural practices. Most of the nurses like working as a "team" member, this was mentioned **20** times in a positive sense:

[I like] to feel part of a team in an excellent practice. To know that back-up is always there from GPs
(NZRGN, 30-39 years, works part time rural practice)

While many nurses find it satisfying to feel a valued member of a team, not all practice nurses feel valued or a team member:

The job is made very stressful by a lack of communication by GP and lack of commitment by nursing colleague; lipservice is paid to teamwork by GP
(NZRGN, 40-49 years, practice nursing full time 10 years suburban practice)
Unless they want to reprimand about some negative aspect of the job there is no positive feedback. I feel (even after 9 years) that I'm just there to do as they bid, that they don't think I've got a status of my own. They don't value my work, the receptionists have more of an even-footing with the doctors than I do.
(NZRGN, 30-39 years, p/nursing 3-10 years full time suburban practice)

[I dislike] being treated as the doctor's handmaiden by some, instead of a complementary health professional
(NZRGN, 40-49 years, job shares, p/nursing 3-10 years suburban practice)

Most (97%) of the nurses are asked for their services directly by the clients. The question which asked the nurses to tick who decides what work they do generated many answers. The majority (53%) indicated that they decided in consultation with the GP. Nine of these nurses also ticked "you do". Twenty nurses (17%) ticked "yourself, in consultation with the team of health professionals who work at your practice" and 17 ticked "you do". Only 7 ticked "the GP". One nurse wrote *"the patients do"*. Some nurses ticked a combination of answers. There were several expressions of individual need for more autonomy and to be allowed to extend the job as they see fit:

> *I would like to have more autonomy but still working in with GPs. There are many more nursing things I could be doing but unfortunately the GPs are our employers and our roles are restricted due to financial restrictions. For example I would like to do more cervical smears and ear checks but the GP can charge more and claim the subsidy*
> (NZRGN, 30-39 years, p/nursing full time 3-10 years suburban practice)

> *...more autonomy from the doctors would be welcome eg the subsidy payment to me rather than them*
> (NZRGN, 40-49 years, p/nursing 11-20 years full time suburban practice)

> *...not extended enough - I try to put more into my position eg currently establishing ESOL sheets for our Asian patients, previously acquired skills not being utilised as I have worked extensively with other cultures*
> (NZRCN, 40-49 years, p/nursing 3-10 years full time suburban practice)

Some nurses however enjoy a degree of autonomy:

> *I work independently of my doctors, they have the confidence to let me do my own thing, I like the responsibility*
> (NZRGN, 25-29 years, p/nursing 1-2 years full time suburban practice)

> [I like the] *responsibility of "call" when Doctor has days off*
> (NZRGN, 51 years old, p/nursing 3-10 years rural practice)

I enjoy the fact that I do have responsibility to provide Child Health Service in the practice - this involves Well Child Checks and most of immunisations
(NZRGN, 30-39 years, works 26 hours suburban practice)

There were some references to wages and to contracts:

...pay is really not enough for the job we do, we have a very responsible job and I don't believe we are compensated well financially
(NZRGN, 40-49 years, p/nursing 11-20 years full time suburban practice)

...it would be nice if we could see our own patients and charge for our services eg to be able to get GMS and ACC, also to be able to prescribe
(NZRGN, 40-49, p/nursing 3-10 years part time suburban practice)

...poor pay, no working contract, no credit given for jobs well done
(SRN[UK], 30-39 years, works full time inner city practice)

Lately there has been some bad feeling over employment contracts. The doctors were very taken aback when we got the Nurses Organisation involved
(works full time suburban practice)

It would seem that some practice nurses see the provision of the salary subsidy as allowing them to provide certain services which they are often unable to do, either through the lack of time and space, or because the doctor wants to do them her/himself. These issues are reflected in the comments about pay and responsibility. This varies from practice to practice but there is a sense that the boundaries between the doctor's responsibilities, and those which the nurses assume, are flexible. This creates difficulties for some nurses.

When asked if they were part of the general management decision making process **53%** nurses felt they were to a limited degree, **36%** felt they were to a considerable degree, and **11%** did not feel they were at all. The responses

alerted me to the current trend to employ practice managers - how does this impact on the work of practice nurses?

The nurses working in rural practices worked more with sole practitioners (40%) than do nurses in inner-city practices (6%). The nurses working with sole practitioners in rural areas did not however report a greater part in the decision making process. Only one of them worked full time. All but one of the nurses working at inner city practices work with two or more in a group practice. In the suburbs 15% of the nurses work with a sole practitioner, and 71% work with two or more in a group practice. Only 13% work with one doctor in a group practice in the suburbs, and overall only 9% report working for one doctor in a group practice. This suggests most practice nurses are being shared among different doctors in group practices.

The question of space within the practice was one about which practice nurses feel strongly. Twenty-two percent nurses said they had no space from which to work; 51% said they had their own space but one nurse qualified this by writing that she shared with 8 other nurses so perhaps they did not all understand their own space to mean their own personal space. Twenty-seven percent said they shared a designated area. Twenty-nine percent gave "lack of space from which to work" as a constraint against extending their scope of practice and there were many comments in the open-ended questions about lack of space:

> *...rooms too small to allow for privacy for patients who wish to see me.*
> (NZRGN, 30-39 years, p/nursing 3-10 years part time inner city practice)
>
> *No room to call one's own. Have crowded nurse's station*
> (NZRGN, 50-59 years, p/nursing 11-20 years full time suburban practice)
>
> *...not enough space - med. centre is owned by the council which houses 2 GPs and practice nurse and district nurse and physio and dentist and optician on certain days of the week*

(NZRGN, 30-39 years, district and practice nursing rural practice 3-10 years)

Some nurses feel the location of the job in general practice offers them access to further learning and acquiring new skills as well as putting practical nursing skills into practice. Eighty percent of the practices the nurses work in are computerised, some of these are still being set up but nearly all are used for recall.

[I like] continually learning new things and adapting to changing circumstances
(NZRGN, 30-39 years, works 10 hours suburban practice, p/nursing 3-10 years)

[I like] varied skills learnt ie suturing, local anaesthetics, emergency situations; constant learning and access to changing information
(NZRGN, 30-39 years, p/nursing 3-10 years 21 hours rural practice)

...opportunity to utilise a lifetime of varying skills learnt in the university of hard knocks
(NZRGN, 60 years, p/nursing 7 years full time suburban practice)

Some nurses compare practice nursing favourably with nursing in a hospital:

...it's nice to be able to relax a little and give support to the community compared to high stress hospital nursing with little thanks and being so institutionalised and please the hierarchy but I have gained invaluable experience in the hospital that I can now use in the general practice (NZRCN, 30-39 years, p/nursing 1-2 years, job shares suburban practice)

You are not looking after very sick people as in the hospital situation, you are helping people live in the community
(NZRGN, 30-39 years, p/nursing 1-2 years part time suburban practice)

...no nursing head to answer to
(SRN[UK], 30-39 years, working less than 1 year full time inner city practice)

4 THE NATURE OF THE JOB

There were such a variety of both positive and negative comments about the work of practice nurses that I have grouped them loosely in an attempt to reflect on them. The positive aspects mentioned most often were:

1 the rewarding aspect of helping people;

2 the patients being part of a community to which the nurses also belonged, being people of all ages and not necessarily ill for whom the nurses could provide continuity of care;

3 being part of a team they felt was successful;

4 the opportunities for extension and some autonomy;

5 and a favourable comparison with hospital nursing.

In comparison the negative aspects included:

1 the busy and tiring nature of the work;

2 the reception and clerical tasks they were asked to do;

3 tensions with their employers and also difficult patients;

4 and the lack of space for them to work from.

The nurses also constantly mentioned the variety of situations the job offers:

> *...the day-to day contact with a variety of individuals is very stimulating*
> (NZRGN; 50-59; p/nursing 1-2 years; job shares in rural practice)

> *The great variety of the position is so interesting*
> (NZRGN; 50-59 years; p/nursing 3-10 years, part-time rural practice)

> *...variety of skills needed in my role, every day different, unpredictable*
> (NZRGN; 40-49 years, p/nursing full time 3-10 years rural practice)

However, I also got the impression that this variety of work, individuals, and

skills needed is, for some nurses, both stressful and constraining. There were many references to being "*too busy*" and being *"tired"*:

> *[I dislike] pressure to "push people through" and not having adequate time to listen and counsel when busy*
> (NZRGN; 30-39 years; p/nursing full time 3-10 years suburban practice)

> *...very busy practice and no time for educational opportunities (often too tired for evening meetings)*
> (NZRGN; 60 years; full time 7 tears suburban group practice)

> *It's tiring and sometimes very constant. In the ideal situation people would be in the right place at the right time - doing the right thing. Some days its a breeze and it flows - others - its at you from all directions and our systems break down - we have to keep putting systems in place - it keeps evolving because the practice is evolving and growing*
> (NZRGN; 50-59 years, p/nursing full time 3-10 years suburban practice)

> *...not enough time for education - never get caught up with routine work and administration*
> (NZRGN; 40-49 years, full time 11-20 years rural practice)

> *Some situations, people and their problems are not able to be improved, as we all know! But sometimes this leaves me frustrated, upset, and down and because of confidentiality in a small town, no-one to share the problem with. I get tired!*
> (NZRGN; 40-49 years; p/nursing full time 3-10 years rural practice)

They dislike certain aspects thoroughly, most notably clerical and reception duties. There were a few nurses who thought it was a very important part of the work especially when it includes the phone, but 32% of the nurses marked clerical and reception duties as the least important in the list they were asked to grade.

> *[I dislike] a certain amount of reception work. Drs not always being aware of work going on behind the scenes - telephones etc*
> (NZRGN; 40-49 years; p/nursing full time 3-10 years suburban practice)

> *...receptionist for an hour in the morning - rest of the time we are*

meant to answer the phone and process patients coming and goings on the computer - this is often difficult and demanding - as well as carry on with "nursing" duties
(NZRGN; 50-59 years; p/nursing 11-20 years, part time rural practice)

Negativity is constant filing of letters and results
(NZRGN; 40-49 years; p/nursing 3-10 years, part time rural practice)

It seems that the boundaries between practice nurse and clerical worker are ones which shift back and forth, and the degree to which this happens varies according to a variety of other factors such as the work load on a particular day, or management decisions about the number of receptionist hours provided for. The nurses have to do a certain amount of paperwork, and there were several comments about the increasing *"paper war"*. The combination of the current health reforms and the resulting confusion and extra work this generates, and the position practice nurses find themselves in of supporting both the doctor and the patient, ultimately affects how the practice nurses see themselves valued.

[I dislike] the amount of paperwork we have to carry out to justify our work to the CHE (which provides our funding), to enable us to have continued funding, there is little co-operation from the CHE in rural areas for ongoing nursing care at home
(NZRGN; 40-49 years; p/nursing 3 years part time rural practice)

...the lack of understanding by other health professionals (ie cervical screening programme, health administrators and planners at Regional Health Authority and Govt level) of the role of the practice nurse. At times we are overlooked, a recent example being the decision to improve immunisation levels by allowing Plunket nurses to administer vaccines without consulting with practice nurses
(NZRGN; 40-49 years; part time 3-10 years in rural practice)

[I find stressful] being the last ones to find out about vaccination changes ie with Hep B and HIB - the media knew more than we did because the Health Dept hadn't sent the directives out; trying to keep up with the social services available, continual changes and RHAs not always aware either (A type of Citizens Advice for GPs would be of great help)

(NZRGN; 30-39 years,p/nursing full time 3-10 years suburban practice)

I find it stressful dealing with the taking of money for services rendered and explaining the most recent changes to subsidies incurred by the government. People's expectations of health care facilities are unrealistic. They think that everything can be cured or fixed almost instantly with very little alteration in their own lifestyle.
(NZRGN; 40-49 years; job shares suburban practice, p/nursing 3-10 years)

The Practice Nurse Division logo is accompanied by the phrase "Practice nursing - more than meets the eye". From the responses to the questionnaires practice nurses seem to be adept at combining nursing, organisational, and clerical skills. Their work seems to demand versatility. One nurse summed it up:

...the dual role of being practitioner and "helpmate" to the GP; always the go-between the GP - receptionist - patient etc demands coming from all angles; constant interruptions by telephone and doctors needing something; sometimes too wide a variety of things expected of us eg stocking urine jars - counselling depressed patients - counting the linen - organising huge volume of educational material - sorting out appointments with specialists...
(NZRGN; 40-49 years, full time suburban practice)

5 IMPLICATIONS OF DATA

The overwhelming impression I got from reading through all the questionnaires as they came in was that most practice nurses find their work very varied, extremely busy, and most rewarding. The nurses also articulate constraints and raise issues which can only be explored at a superficial level through such a method as a questionnaire, and which need further research to be substantiated.

The responses showed several contrasting situations experienced by practice

nurses in differing practices, and a wide variety of work done by practice nurses. There were many comments on the satisfaction most practice nurses feel in dealing with members of the public, with teaching health prevention, with having the knowledge and the authority to access relevant agencies to help people in various situations. There is a sense that the practice nurses can have considerable influence as primary health workers, yet there is also a sense of frustration that this is limited and undervalued:

> *Doctors sometimes consider the nurse's patients are less important than their own yet all is done for the benefit of the Doctor's patients - they all "belong" to him even if they prefer to see the nurse*
> (NZRGN; 50-59 years; p/nursing 11-20 years full time large suburban group practice)

Although the practice nurses who compared their work in general practice with nursing in a hospital location did so favourably, this was generally in terms of increased autonomy and variety of situations dealt with, rather than as a professional career path. On the other hand, there are some practice nurses who see their position as crucial in the current climate where prominence is given to health maintenance and disease prevention:

> *The role of the practice nurse has expanded greatly in recent years and I can see that the role can expand even further in the future as a result of the health reforms. It is a positive and exciting time for primary health care teams.*
> (NZRGN; 30-39 years, p/nursing 11-20 years job shares 24 hours in suburban practice)

Some practice nurses are practising in different, innovative ways, for example, the practice nurse who works one of her days as health promotion officer. It seems that most practice nurses want to be part of a team and assume that the team will be lead by a doctor. At the same time, the responses indicate that it is possibly the practice nurses themselves who are ensuring that teams of health professions do work constructively together.

Most practice nurses think organising the practice so things run smoothly is an important part of their work, but they also think practical tasks such as dressings, teaching about health maintenance, and preventive screening programmes are also very important. The issue of having to be so versatile is one which needs exploring. It raises the other issue of the boundaries drawn between nursing tasks and administrative or clerical work, and the degree to which this extra work impacts on their time. It alerts me to the changing nature of general practice itself - the growth of related services such as counselling and sports medicine which are now often incorporated into the same location - how does this affect the position of practice nurses?

The questionnaire has proved a valuable tool with which to initiate the research, and has raised a variety of issues to be explored. The practice nurses who responded have done so generously in terms of offering qualitative comments which one does not normally expect from a quantitative method such as the use of a questionnaire, and also in offering to be contacted at a later stage.

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APPENDIX "E"

Niall Holland
MB, BS, MRNZCGP

Hagley Hostel
Christchurch School of Medicine
P.O. Box 4345
Christchurch
Telephone (03) 364 0410
Fax (03) 364 0451

The Allen & Hanburys Postgraduate Tutor in General Practice

Ms Belinda Mortlock
23 Kotare Street
CHRISTCHURCH

5 October 1993

Dear Belinda,

Calder Botting has passed on to me as Chairman of the Research Committee of the Canterbury Faculty of the Royal New Zealand College of GPs your proposal for an MA Thesis researching the role of the Practice Nurse. As you state, this is likely to be a sensitive issue, particularly in the current climate. You may find some practices reluctant to contribute at this stage. Practice Nurses are a valued and busy part of most practices. It will be essential that Nurses not be distracted from patient care while helping with the research and so you may find practices reluctant to spare Nurses during work hours. However your proposal to participate yourself in Practices may be seen as compensation.

I note that in your discussion you quote the subsidy rate as being 75% of the current hourly rate. The subsidy of $11 an hour includes 12.5% GST which has to be returned to the Government. In effect this reduces the subsidy to, I think 63% of the Nurses wage. Additional costs such as ACC levies etc are met by the GP.

In the near future the Pegasus Group will be handling subsidies for general practice services in the Christchurch area for most GPs. This will include the Practice Nurse subsidy and the way in which it is managed will impinge significantly on the role of the Practice Nurse in the next few years. However, Nurses have become such an integral part of the primary care team that I would be very surprised if they ceased to have an important role in primary care.

Dr Lanktree Davies of Shirley Medical Centre edits the Newsletter for the Canterbury Faculty of the College. I would suggest you prepare a brief statement for inclusion in this Newsletter seeking contributions and cooperation from GPs. Do always bear in mind that there is a sense in which Practice Nurses could operate in competition with GPs and that this will influence the response you receive from GPs.

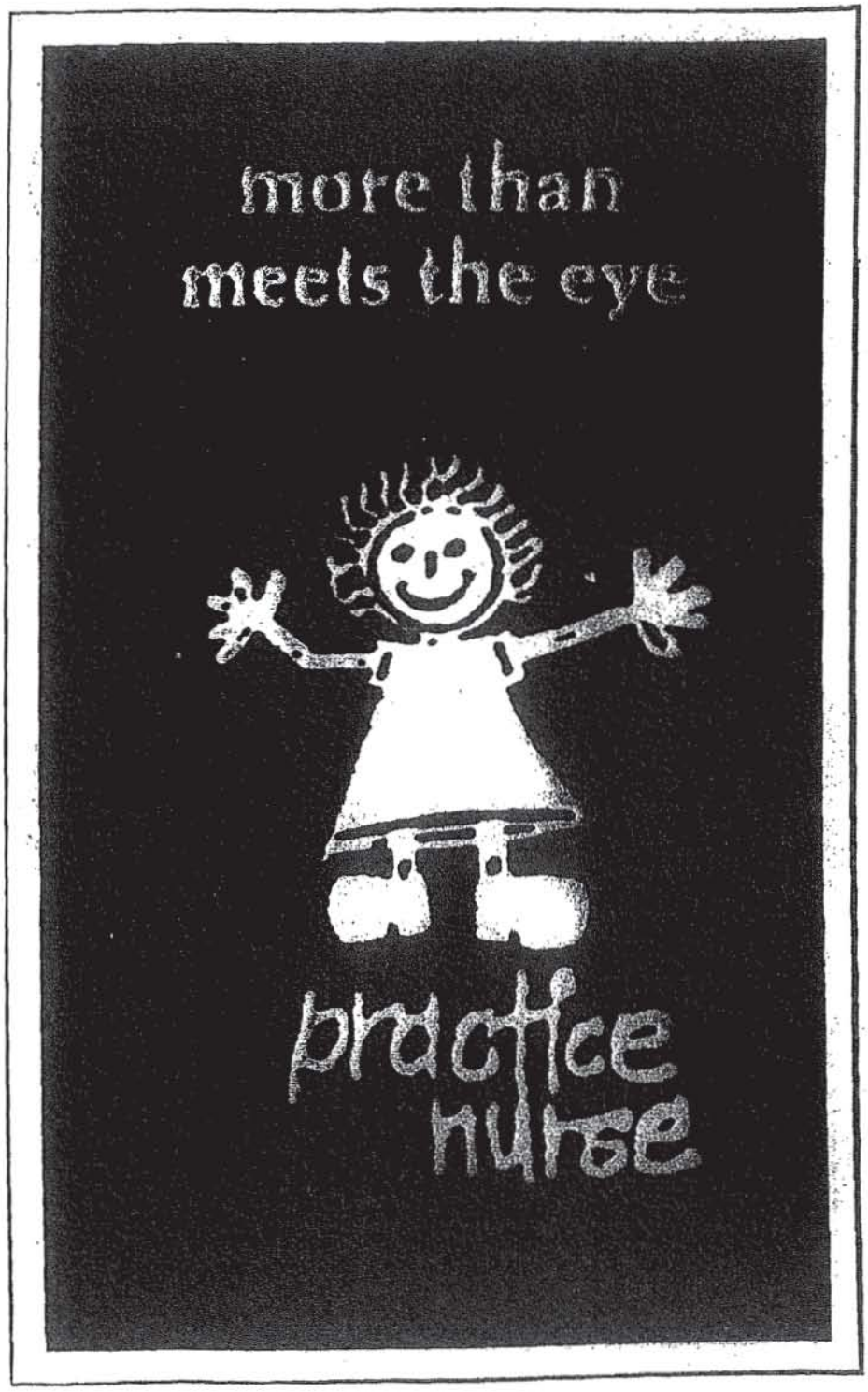
All the best with what sounds like a very interesting project.

Yours sincerely

Niall Holland
Allen & Hanburys
Postgraduate Tutor in General Practice

copy to Canterbury Faculty of the College

APPENDIX "F"



Copy of Logotype from article by Carol Brown, 1994. "Practice Nurses Settle Contracts" in *Nursing New Zealand*. July p.30.